BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF WASHINGTON

In the Master of the Application regarding the Conversion and Acquisition of Control of Premera Blue Cross and its Affiliates,	Docket No. G02-45

Adjudicative Hearing
May 7, 2004
Day 4
Tumwater, Washington

Taken Before:

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INDEX

EXHIBIT INDEX

NO.	DESCRIPTION	OFFERED	ADMITTED
P-36	Pre-Filed Direct Testimony of Brian Ancell, filed 3/31/2004	794	794
P-37	Pre-Filed Responsive Testimony of Brian Ancell, filed 4/15/2004	794	794
P-39	Washington State Department of Health, Center for Health Statistics, Hospital Data, and Financial Ratios, dated 4/15/2004	815	815
P-40	Pre-Filed Direct Testimony of Rakesh "Roki" Chauhan, filed 4/15/2004	930	930
P-41	Pre-Filed Responsive Testimony of Rakesh "Roki" Chauhan, filed 4/15/2004	930	930
P-49	Pre-Filed Direct Testimony of Richard Furniss, filed 3/31/2004	731	731
P-50	Curriculum Vitae of Richard Furniss	731	731
P-51	Report of Towers Perrin, filed 11/10/2003 (with corrections)	731	731
P-52	Supplemental Report of Towers Perrin, filed 3/5/2004	731	731
P-53	Pre-Filed Responsive Testimony of Richard Furniss with exhibits, filed 4/15/2004	731	731
P-68	Pre-Filed Direct Testimony Alan Smith	953	953

EXHIBIT INDEX

NO.	DESCRIPTION	oFFERED	ADMITTED
P-69	Article in Gartner Dataquest: "In Unforgiving Times, the U.S. Healthcare Market Boosts IT Spending." August 2003	953	955
P-71	BCBSA News: "BCBSA Study Reveals Coding Shift Could Cost Healthcare Industry $14 Billion"	953	955
P-72	Healthcare IT News: "Kennedy to offer HIT bill"	953	955
P-73	HHS Fact Sheet: "Protecting the Privacy of Patients' Health Information"	953	955
P-74	Premera Blue Cross Press Release "GAO Report: Technology Invest-ments by Premera Blue Cross, Save Millions, Improve Service and Quality of Care"	953	955
P-75	Pre-Filed Direct Testimony of Brian Kinkead, Filed 3/31/2004	874	874
P-76	Resume of Brian Kinkead	874	874
P-77	Banc of America Securities ("BAS") Report, dated November 10, 2003	874	874
P-78	BAS Supplemental Report, dated March 5, 2004	874	874
P-79	Pre-Filed Responsive Testimony of Brian Kinkead; filed 4/15/2004	874	874

EXHIBIT INDEX

NO.	DESCRIPTION	OFFERED	ADMITTED
P-80	Excerpts from Deposition Transcripts of Jonathan Koplovitz and Martin Alderson-Smith	874	874
P-81	Comparison of Premera's Revised Form A with precedent transactions	874	874

P R O C E E D I N G S

JUDGE FINKLE: Good morning. Let's proceed. I do have a couple of quick rulings for you. The redactions at E-6 and E-8 of the Nemerov testimony will be allowed. Those were the two disputed redactions; in other respects the testimony would be released. As to the prefiled testimony of James Johnson, there are no edits to that, it may be used as submitted.

Ready for the next witness?

MR. KELLY: Yes, we are. We call Richard Furniss.

JUDGE FINKLE: Mr. Furniss, would you come forward and be sworn.

RICHARD FURNISS, having been first duly sworn by the Judge, testified as follows:

DIRECT EXAMINATION

BY MR. KELLY:

Q. Would you please state your name.

A. Richard Furniss.

Q. Could you state your position and your business.

A. I am a principal with Towers Perrin. Towers Perrin

is a management consulting company based in New York City.
Q. Can you tell us about the work that your firm, Towers Perrin, does?
A. Towers Perrin is a human resource consulting company, as well as an actuarial consulting company. We have approximately 80 offices around the world and approximately 8,000 employees. We assist companies in evaluating and designing compensation and benefit programs, as well as assisting insurance companies in actuarial consulting.
Q. Can you describe your education, please?
A. I have a Bachelor of Science in mechanical engineering from the University of Pennsylvania, and Master of Business Administration, also from the University of Pennsylvania.
Q. Tell us about your career in the field of executive compensation consultation?
A. My first jobs out of college were with the Dupont Company, and then I left and joined the General Consulting Company. I joined Towers Perrin in 1978 and have been there ever since.
Q. What's the focus of your work at Towers Perrin?
A. I work in executive compensation exclusively, and I direct the firm's practice in executive compensation for

the insurance industry.
Q. Do you work on compensation for a wide range of insurance companies?
A. Yes, I do. I work for property casualty, life and health companies. I work for -- I have worked for public stand-alone companies, for subsidiaries of public companies, and for mutual companies for fraternals and for not-for-profits.
Q. Now, your prefiled direct and responsive testimonies, your curriculum vitae and the Towers Perrin's reports that you prepared, have been served and filed in this proceeding. You adopt all of them?
A. I do.
MR. KELLY: Mr. Furniss's prefiled direct testimony has been marked as Exhibit P-49, his CV is P-50, the original Towers Perrin report is P-51, the supplemental report P-52, and the prefiled responsive -- the numbers are wrong here, is P-53.
And with the adoption of his testimony and those documents by Mr. Furniss, we move to admit those exhibits.
MR. HAMJE: No objection.
JUDGE FINKLE: Admitted.
BY MR. KELLY:
Q. To start with, asking you what you did in this case

as part of the initial groundwork for preparing your reports?

A. The first step in analyzing the -- or assessing the compensation program, the executive compensation program of Premera, we developed a clear understanding of the company's compensation philosophy. We believe that's the groundwork of any compensation program.

The next thing we did was to determine how the company is organized and staffed, what the specific responsibilities are of the senior executives. And the third thing we did was to get a clear understanding of the present compensation arrangements, and not only how they are formally structured, but how they are actually administered and practiced.

Q. For each of those let me ask you, how did you go about ascertaining, first, the company's compensation philosophy?

A. The primary input for the company's compensation philosophy was a discussion with the compensation committee head and another senior director who served on the compensation committee.

Q. Who is the head of the compensation committee?

A. Mr. Fahey.

Q. And the other senior director who had served on the committee before, who are you referring to?

A. The witness yesterday.
Q. Is that Ms. Jewell?
A. Ms. Jewell.
Q. On the first day actually?
A. Correct, first day.
Q. Did you also have any discussion with Mercer Consulting?
A. Yes, we did. We discussed these subjects and more with the Mercer Consulting, Diane Doubleday, the head of the Mercer team that worked on this assignment.
Q. Perhaps, for the record, you should indicate who or what Mercer Consulting is and what role they have with Premera.
A. Mercer Consulting is a major human resource company that competes directly with Towers Perrin. It is a large, very well-respected firm, and they are Premera's regular consultant on executive compensation matters and have been for several years.
Q. Okay. Going on to the second groundwork activity that you started out with with this assignment, how did you learn about Premera's organization and its structure?
A. We learned -- of course we got input from talking to the compensation committee and director member, but we gathered the actual organization from several sources.

We had a great deal of written material that we examined, but we also talked to specific executives. Reading the written material provides us with a great deal of interesting information, but without talking to the executives we feel that we don't really have a good idea of how the company is organized and how responsibilities are aligned.

Q. Okay. And the third groundwork activity I think you testified about was learning about the design and administration of the actual Premera executive compensation program. What did you do to learn about that?

A. There again, we read the written material, which are quite detailed in how the plans are designed and can be administered, but we found in Premera, as we find with other companies, that the actual administration may differ, it may be more liberal -- it won't be more liberal than the plan's design, but it may be stricter and more formula driven, for instance, and it may or may not use some of the latitude the plan design allows you to use. So, here again, we had to discuss with the senior executives how the plan was actually administered.

Q. Okay. Now, what about job titles, is that something that you looked at as a consideration?

A. Of course we look at job titles, but we never rely on them for senior executive decisions, without discussing what additional functions given positions have, or perhaps what fewer functions they have than general industry.

Q. Now, once you had obtained this groundwork information, what did you then do?

A. Then the next task is to compare Premera's compensation or our client's compensation with survey data and market data. What we are trying to do is to develop a picture of the market for each position. It may be as simple as matching job titles, but it very seldom is in a senior management position.

Usually the only title that is a clear match is the CEO. From then on, responsibilities below the CEO are not necessarily a function of job title. So we need to determine whether or not the market compensation for specific job titles should be increased or decreased.

For market compensation we use proxy data, which is very useful for public companies, provided it is interpreted and not taken simply off the compensation page.

For -- in order to include companies that are not public we use survey data, which is produced by companies that conduct exclusive surveys in this

industry.

For both proxy data and survey data we match the size of the company. So the median of the data or the 75th or the 25th gives us a benchmark against which we can compare the client.

Q. You are looking at an industry, a health industry, is that what you are doing?

A. Correct, we are looking at the health industry.

Q. When you use the term proxy data, is this for a record -- what is the source?

A. Public companies are required to file proxies annually, and within these proxies they are required to -- not only provide the value of the compensation delivered for the past three years to their top five executives, but the compensation committee is required to write a report. And between that report and the footnotes, we have a -- we are able to determine how the plans of these various companies are structured and administered.

Q. Then, after preparing all that data, you wrote up a report which actually utilizes the data to ascertain where Premera's executives fit?

A. That's correct. It is called a benchmarking process, and we compare then Premera's executives with the data from the market. We are determining the market

for positions, not the people. So we don't make any attempt to determine whether an individual is performing better or worse than the market, but we do take -- our primary objective is to determine what the market is for this particular set of scales for each position.

Q. And is that process that you went through as an expert here of gathering data, making comparisons, similar to what Mercer Consulting does on a regular basis when providing advice to Premera?

A. Yes, it is. We talked at some length to the Mercer Consulting -- to the Mercer consultants and ascertained that's the same way they did it.

Q. Is that the usual approach in your business?

A. It is the usual approach in our business. To do it right, that's about the only approach.

Q. Okay. Now, let's turn then to your analysis. First, who is it that articulates Premera's compensation philosophy?

A. Premera, as with other companies following the best practices in the industry today, within Premera, it is the compensation committee of the board that articulates the philosophy. There is input to it, of course, from management, but it is ultimately the board's responsibility to articulate and administer the compensation clause.

Q. What does your report indicate are the key elements of the Premera compensation clause?
A. The key elements, from our perspective, that we focused on, were that Premera had selected or had determined as a peer group, a reference group, health insurance companies of like size, both for-profit and not-for-profit.

The second element was to position their pay at the median for a target performance of this peer group, except where certain positions were required -- certain positions required extraordinary skills or talents specific to the task at hand.

In other words, if they had to recruit someone to do a particular job outside the -- even outside the median pay level that we determined, they are willing to pay for that.
Q. And is that exception, where there is a need to obtain the person or the person has extraordinary skills, is that type of exception found throughout the industry?
A. Absolutely. I don't know any company and any industry that isn't willing to do that.
Q. Now, is compensation, for individual positions under the Premera compensation philosophy, determined based upon industry job definitions or actual management

responsibilities?
A. It is based on actual management responsibilities.
Q. And is that the second key element of the philosophy of Premera towards compensation?
A. Yes. To find out, rather than using job definitions, which would be the quick, easy way to do it -- job titles rather, Premera is willing and ready to determine compensation based on the actual responsibilities of the position.
Q. Is that what is done throughout the industry, to look at actual needs rather than job titles?
A. It should be.
Q. Okay. And is that what you recommend?
A. That's what we recommend.
Q. What's the third key element of the philosophy about the use of peer groups, what would --
A. The peer group is that -- the frame of reference or the peer group or the peer industry that Premera uses is public and non-public companies. They recruit from public and non-public companies, they are vulnerable to losing people to public and non-public companies. The majority of the executives at Premera have worked at public companies and they compete for business with public companies. So we concurred that this element of the philosophy was entirely appropriate.

In fact, if the philosophy had been one that didn't make sense to us we would have questioned it and we wouldn't have just followed it. Simply having a philosophy is not enough, but it had to make sense based on the business needs.

Q. So what's your overall conclusion about Premera's executive compensation clause?

A. The executive compensation philosophy, we believe, is entirely appropriate for this business -- for this company at this time -- and we believe it follows the best practices that we are seeing more and more in the industry.

Q. Now, did you also, as part of your report and investigation, ascertain the involvement of the compensation committee and Premera's board in making executive compensation decisions?

A. Yes, we did. We were actually delighted to find that there was a very heavy degree of involvement on the part of Premera's compensation committee, and the board where necessary, in the administration of the compensation program.

This, I believe, all of us are finding is a growing trend, but unfortunately it is not universal yet. In Premera's case, the board meets in executive session, in other words, with no executives present, among

themselves and with Mercer, to set performance goals, to assess the compensation increases if they are necessary, and monitor the overall compensation program.
Q. Okay. And is the compensation committee and the board involved in the design and review, as well as the administration?
A. Yes, they are. They have a very heavy role in reacting to proposals from Mercer and asking for proposals from Mercer and in modifying programs the way they are now.
Q. When you say in executive session, what does that mean? Who leaves the room when executives -- for purposes of executive comp?
A. The management leaves the room.
Q. Okay.
A. The independent directors remain in the room.
Q. Along with -- or they have at least available Mercer Consulting to advise them as well?
A. That's correct.
Q. Okay. Now, how is the compensation committee aided in its work by having access to an executive compensation consultant such as Mercer?
A. An executive compensation consultant, such as Mercer or such as Towers Perrin, can serve several roles. One, is to educate the committee in what is going on. We

spend all day, every day, dealing with executive compensation matters. The independent directors don't have full-time to do this.

So they can educate -- the consultants can educate the committee in trends and new plan designs and what other companies are doing. They can also -- and they should -- provide an objective perspective on the peer group and the market value of each job and recommend where Premera ought to position their pay levels versus these markets.

Q. What's your conclusion as to the compensation committee and the board at Premera in terms of their involvement in executive compensation?

A. We think it is a very healthy balance between -- I guess you would call it the three elements of input; management, the independent consultant, and independent directors and board.

Q. Did you assess the work of Mercer Consulting in this case?

A. Yes, we did -- Mercer Consulting? Yes, we did. We reviewed their reports, and, as I say, we held frank discussions with Mercer Consulting who were quite cooperative with us on how they did the same kinds of things that we did -- how the plans were designed, why they were designed that way, the peer groups and the

like.
Q. How did your analysis compare with Mercer?
A. Ours was quite similar to Mercer's. We used slightly different techniques. All consultants have developed their own ways of valuing various components of pay, but their results are very close to ours.
Q. And did you put forth those comparisons of results between yours and Mercer's in your report, your first report?
A. Yes, we did.
Q. And what was your conclusion as to the approach that Mercer Consulting was taking?
A. We believed it was entirely appropriate and quite professional.
Q. What about the relationship between Mercer Consulting and Premera, what's your assessment of that?
A. Again, we felt it was a very healthy relationship, particularly because of the involvement in the board.
Q. Now, let's turn to Premera's current executive compensation program and ask two parts. First, what's your opinion regarding the forms of compensation that Premera offers?
A. We believe the three forms of direct compensation, which is primarily what I am addressing, are entirely appropriate. There is base salaries, there is an annual

incentive plan, and there is a long-term incentive plan. Because they are not public, all of those are cash-settled plans.

Q. Can you just elaborate on that a little bit?

A. On the last statement?

Q. Yes.

A. Okay. The public companies, of course, use stock options or stock-based plans typically for their long-term compensation. Premera as a private company is required to use cash which, of course, is an expense.

Q. Now, you said there is annual bonus opportunity and then there is a long-term incentive, why the two different types of plans?

A. Most companies will adopt both kinds of plans. The annual incentive plan is supposed to highlight the things that need to be done in a particular year. The long-term incentive plan is supposed to encourage and reward things that take longer than one year to do.

The annual incentive plan at Premera for the senior executives is driven entirely by financial performance, goals are set each year, profit goals are set each year, and depending on the financial performance, whether it is above or below target, nominal awards are made, and then those awards can be reduced according to the tactical goals that are set, such as marketing and

membership and quality of products and things like that. So they are all included, but the dominant performance measure in the annual plan is profit.

Q. And then the approach for long-term incentive --

A. The long-term incentive plan also is typical in a not-for profit healthcare organization. It includes operating income, but it also includes other measures, such as growth and membership.

Q. Because the long-term plans presumably involve growth of membership and other factors in addition to the operating --

A. That's correct.

Q. Now, that's the forms of compensation for the current plan. What is your opinion regarding the amount of compensation received by Premera's executives under that plan?

A. We found the amount of compensation to be quite consistent with the philosophy. We found the aggregate pay was where it ought to be, it was at the median of the market, with one exception, and that's the individual that was hired to pursue the best project, to develop the best project, he was also the chief actuary, and he had extraordinary skills, talents, and responsibilities. He is now retired. He was paid appropriately above median. Otherwise, we found that

the pay was exactly consistent with the philosophy.
Q. That person was -- is that Andrew Wang?
A. Yes, it was.
Q. And so what's your conclusion as to whether the levels of compensation are reasonable and appropriate to job responsibilities?
A. We believe they are entirely appropriate to the philosophy, and we believe the philosophy is entirely appropriate, given -- in light of Premera's business plan structure competition -- competitive environment.
Q. Okay. And you have a more detailed discussion of the current compensation in your reports?
A. Yes, we do.
Q. Okay. Let's turn then to your views on Premera's post-conversion executive compensation program or programs. What is your opinion regarding post-conversion executive compensation?
A. In general or for Premera?
Q. For Premera.
A. As we understand the proposed compensation program following conversion, it will -- the forms of the cash plan, the performance measures of the cash plan can be changed, but they would pursue profit and the other measures necessary to create -- to represent value. There would be an additional component to the long-term

program, and that would be a stock option program.

Premera has agreed to wait a year before making any grants of stock to the executives of any form. Premera also intends at this time to combine a restrictive stock pay out with the conventional program, what I would call the current cash long-term incentive program, to further align the relationship between executives and management. But that stock would be paid in lieu of cash. The new piece would be an option piece.

Q. We will talk about that option piece in a minute. But holding that aside, what is your opinion as to whether Premera's post-conversion compensation plan will be reasonable and appropriate?

A. We believe that it is a reasonable and appropriate plan also.

Q. Is this type of mix of compensation that you just described for Premera, how does it compare to mixes of compensation in the health insurance industry?

A. Some companies rely exclusively on options. There is currently a great deal of interest in the world of compensation on including non-option plans, such as Premera's long-term incentive plan, for two reasons. One, to ensure that measures that aren't immediately translatable into stock growth are included in the performance measures that executives pay attention to,

and also to make sure that they are not overly concerned about stock price increasing only.

Q. What does Premera's plan have in that regard? Does it have a mixed --

A. Premera has an appropriate mix. The long-term plan can include performance measures that relate to service or quality or growth membership or the like. The stock option plan will relate only to share price growth.

Q. What role will the compensation committee have in regard to Premera's post-conversion compensation?

A. We have every reason to believe that it will be at least as strong as it has been. Public companies are under a great deal of scrutiny, as are the compensation committees and the boards, and we are quite comfortable that the board will continue to exercise appropriate oversight -- and involvement more than oversight.

Q. So there will be actually some public exposure with post-conversion to the question of executive compensation?

A. A great deal of public exposure.

Q. In fact, the proxy statements that you referred to as part of the survey data that you obtained would then be available in Premera's --

A. That's correct.

Q. Now, are you aware that there are some additional

compensation assurances that were put into the Amended Form A when it was filed in February of 2004?
A. Yes, we are.
Q. And will those compensation assurances provide additional comfort that Premera's post-conversion compensation will be appropriate?
A. Yes, they will, a great deal of comfort.
Q. And for the record, so the Commissioner knows, those are in Amended Form A, but they are only -- they are also known as Exhibit E-8 in the Amended Form A, and they also appear as a stand-alone exhibit for convenience as Premera's hearing exhibit P-55.

A little confusing, because they have three titles, the one document has three titles. They are -- the first two pages are I believe -- two and three -- are Washington Economic Assurances, then there is Alaska Economic Assurances, and then there is the Compensation Assurances which are the last two pages. Just for the record.

Let's turn to the question of the stock portion of Premera's post-conversion compensation plan, I guess known as the Equity Compensation Plan; is that correct?
A. That's correct.
Q. Now, why do publicly-traded companies make stock options a part of their compensation package for their

senior executives?
A. Stock options provide perhaps the purest form of linkage between executives -- maybe some people think it is the purest -- between executives and employees and the shareholders.
The stock option is designed to show that -- most stock options are and Premera's will be -- designed so that when they are granted they have no value. They simply provide a right to purchase the share of stock -- shares of stock -- at some point in the future, usually up to 10 years -- which is the case for Premera's -- following their vesting period, which is three to four years, at the price at which they are granted.
So there is potential gain to the extent that the share price grows from the grant. If there is no gain, there is obviously -- if there is no gain in share price, there is obviously no gain to the executive.
Q. Okay. Now, if there is no gain in the share price, unfortunate if that happens, these are options, what do people do if there has been no gain in the share price from the time it was granted to them until the time they are available to exercise the option?
A. They complain.
Q. I mean, there is no sense of exercising the option if it doesn't have any upside to it?

A. That's correct. That's correct.
Q. And you used the term vesting period, just for our record, what generally -- what's the concept there?
A. The concept there is that options are not immediately exercisable. They are exercisable traditionally in portions.

So if an option is exercisable over four years, then 25 percent of the total number granted would be exercisable in one year, another 25 in two years, another 25, and so forth.

There are two reasons for that. One is if the stock should spike up immediately after grant, it would probably not be caused by management doing anything, it would be caused by a fluke, and therefore a windfall, no one would benefit from it. The other reason for the vesting period is retention.
Q. Because you have to be around --
A. You have to be around to get it.
Q. You often hear the phrase "aligning the interest of management with those of shareholders" in connection with the stock options. Could you just elaborate on that.
A. Yeah. Stock options have a fairly powerful alignment. If the stock goes up, management benefits. If the stock doesn't go up, management doesn't benefit.

That's a pretty tight alignment, we believe.
Q. What is that designed, hopefully, to do in terms of executive performance?
A. It is supposed to get the executives to focus at the end of the day on the shareholder interest. Now, the way they focus on the shareholder interest could be through cost reduction, it could be through membership growth, it could be through investments, it could be any number of things. But their success in these other things is going to ultimately be reflected in the stock price.
Q. Now, I take it alignment with interest of the shareholders is not at all necessarily in conflict with alignment with the interest of subscribers; is that correct?
A. That's correct. If you have no subscribers, you probably won't have too many shareholders after a while.
Q. Because --
A. There won't be many profits after a while.
Q. You talked earlier about the other aspect of compensation, annual plan, and also the cash, I guess, portion of the long-term plan. How do they help align the interest of the management with the interest of the subscribers?
A. It depends on the performance measures that are put

in there. But if you have, for instance, a quality measure in your annual incentive plan or in your long-term plan, you have an opportunity, executives have an opportunity to get paid for quality, and that measure is distinct and separate as a performance measure in the plan.

Q. Now, you testified earlier that when stock options are granted they have no value. Can you elaborate on that, please?

A. They have no intrinsic value. They have a theoretical value and consultants, loving theory, have developed -- or adopted rather -- the Black-Scholes and other methodologies to estimate the present value of future gain.

Black-Scholes is an extremely complex model, that was originally designed by the investment community, and it is supposed to estimate the present value of a stock option when it is granted. It doesn't predict share price growth, it is more useful for comparing companies with different growth patterns.

If I might tell you that, in my experience, most executives neither understand nor value the Black-Scholes value of an option grant when they get it. And it is not complicated enough for the accountants and the new methodology of accounting for stock options is

going to be even more complex.
Q. But at the end of the day, when you get a stock option granted to you, at that time it is worth --
A. It is worth about zero the day you get it, from a cash point of view. It has no intrinsic value.
Q. What does it have though in terms of the future?
A. It is an opportunity, no question about it. Stock options have a very powerful focus on getting the share price up.
Q. Okay. What is your evaluation of Premera's Equity Compensation plan?
A. We believe it is highly conservative. It is unusual for a company going public to limit the shares that can be granted each year and the shares that can be granted to each executive. It certainly will provide comfort that the equity program in this case is not going to be excessive.
Q. So in comparison with a competitive practice, how does it compare with --
A. More conservative.
Q. There is -- just briefly, because we are running out of time -- what is your assessment of the provision in the Amended Form A that limits the annual total grants -- share grants for the company, over the stock restriction period of 36 months?

A. Highly conservative.
Q. And what about the limitations on specific share grants for Premera's top five executives?
A. Highly conservative and limits the flexibility of the compensation committee.
Q. Would it be appropriate in your view to place any additional restrictions on the stock program?
A. Absolutely not.
Q. What are the problems with further restricting share allocations, for example, among the top five executives?
A. It doesn't allow -- further restrictions would prevent the compensation committee from allocating share grants to meet specific needs at the time. It will make it very difficult to differentiate among executives, and it will make it difficult to meet the changing conditions.

It is very difficult to predict going out three years what you are going to need to do. This is the job of the compensation committee, not arbitrary rules.

Q. The final area, I wanted to ask you if you reviewed Mr. Nemerov's prefiled direct and responsive testimonies in this case and his accompanying reports?
A. Yes, we have.
Q. What general observations do you have about his testimony and reports?

A. There are some areas we agree and there remains some areas we disagree.
Q. What are the areas, if you can just enumerate or give some examples of the areas that you and Mr. Nemerov are in agreement?
A. I believe we agree on the importance of the compensation committee and design administering and exercising oversight over compensation programs.
We agree that the level of pay post-conversion is appropriate. And we believe that incorporating the interest of the shareholder in incentive plans is also appropriate and necessary.
Q. Okay. And does your prefiled responsive testimony discuss at some length the areas where you agree and the few areas where you disagree?
A. Yes, it does.
Q. How would you summarize the differences between your two positions -- the primary difference, I guess?
A. The primary difference is that the PWC report continues to recommend further limits and controls and specific performance measures to be inserted in the long-term plan and annual plans. And believes -- I believe that these should be imposed externally on the compensation committee regarding design and administration of the plans.

Q. What problem do you have with that type of approach?
A. As I said earlier, I don't believe that an external set of rules at this point can anticipate the future needs of any company.
Q. Did Mr. Nemerov acknowledge that other companies in Premera's peer group do not have restrictions such as those that he is imposing here?
A. Yes, he has acknowledged it.
Q. And what type of problems can the rule approach, that Mr. Nemerov seems to be promoting, create?
A. They can limit -- they can unduly constrain the comp committee, the compensation committee, in meeting needs as they arise, for individuals for whom they want to promote, for individuals who haven't done so well. They would like to shift shares from one to the other.

The performance measures that have been suggested are certainly interesting and worthy of consideration by the compensation committee, but certainly we believe shouldn't be adopted as rules. The performance measures are specific to the company and its strategy.
Q. What can happen if the rule today might be appropriate, but may or may not be appropriate in the future?
A. Well, then it is up to the compensation committee to change it. If the performance measures in place today

are not appropriate in two years for this strategy in the business conditions, they can and should be changed, but they shouldn't be imposed today.

Q. Finally, what do you think is the right approach to dealing with the issue of appropriate constraints on stock plans for executives for Premera? In other words, who should be doing that type of control?

A. Well, within the overall limits, which have already been agreed to by Premera to prevent excessive compensation in the aggregate, we believe it is up to the compensation committee to design how these awards are granted.

MR. KELLY: That's all I have. Thank you, very much.

CROSS-EXAMINATION

BY MR. HAMJE:

Q. Good morning, Mr. Furniss.

A. Good morning, Mr. Hamje.

Q. I wanted to visit with you a little bit about your testimony and about your opinions. The first thing I wanted to ask you about is that I understand that at one time Premera was a client of Towers Perrin, I guess for about two or three years, sometime prior to 1998; is that correct?

A. That's correct.
Q. And I also understand that you were not involved personally in working with Premera at that time, but it was an individual -- another individual at your firm that has since retired, who is responsible for assisting Premera in executive compensation design; is that correct?
A. That's correct.
Q. Other than this -- other than your engagement in this matter, Towers Perrin has no ongoing relationship with Premera; is that correct?
A. That's correct.
Q. Now, you also spent some time talking with Mr. Kelly about stock options and how they are generally acknowledged to be the best device for aligning the interest of management with the shareholders; is that correct?
A. If I said that, I may have misspoke. I believe they are one of the best devices. They are currently under -- some people don't think they are the best, others do. I think they are an extremely effective way to do it.
Q. And as you put it, I think, that management receives no gain at all unless the value of the stock increases; is that correct?

A. That's correct, from the grant -- grant price.
Q. And you have also stated that you believe the restrictions, based upon the compensation assurances, are conservative on the stock options; is that right?
A. That's correct.
Q. But even with those restrictions, won't the executives still be eligible for long-term incentive cash payments?
A. Yes, that's my understanding.
Q. Doesn't that mitigate the effect of these temporary stock option restrictions?
A. Yes, it does.
Q. One of the positions that you articulate in your reports and in your prefile testimony is that PricewaterhouseCoopers' -- or PWC's -- recommendation to limit officer-based salary increases to verifiable market rates of percentage increases to executive salaries, should not be accepted because it would unnecessarily limit the board's discretion in those matters; is that correct?
A. That's correct.
Q. But if the proposed long-term incentive opportunity -- and I am excluding stock options for just a moment -- for the top five officers is increasing by as much as, say, 15 percent in 2004, to as much as 30

percent in 2005 as a result of the conversion, doesn't a conservative salary increase make sense to you?
A. Yes, it does.
Q. Now, don't increases to the base salary of the officers, won't they have an impact on other elements of the officer's compensation?
A. Yes, they will.
Q. For instance, bonuses will have an impact if the bonus target as a percentage of salary stays the same; is that right?
A. That's right.
Q. And it will increase?
A. It would.
Q. As well as long-term incentives and other benefits if it is tied --
A. That's correct, like any other company.
Q. And one way that you have differentiated your view from Mr. Nemerov -- Mr. Nemerov's views, is that you have characterized it in your -- particularly in your prefiled responsive testimony -- as, he "would seek to impose rigid rules that try to predict today what will be needed" in a year or two. Does that accurately reflect what you stated?
A. Yes, it does.
Q. On the other hand, you believe the compensation

committee and the board need flexibility to consider Mr. Nemerov's points, but not be handcuffed by them; is that correct?

A. That's correct.

Q. In fact, if I understand your testimony correctly, you and Towers Perrin believe that the board is the primary representative of the shareholders and constituents of an organization, and it is the responsibility of the board to exercise through its compensation committee to make sure that management compensation is fair to the constituents and to management to achieve the goals of the organization; is that correct?

A. That's correct.

Q. And you have also indicated that -- you have concluded that the practices engaged in by the compensation committee and by the board, in terms of compensation oversight, are appropriate and reasonable; is that correct?

A. That's correct.

Q. Would your opinion change if the make-up of the board changed?

A. Well, my opinion had to do with how they have operated up until now. If the board's make-up changed, I don't know how they would operate in the future, but I

have every reason to believe that it would continue. The culture at Premera seems to -- Premera board seems to be --

Q. Would your opinion change if the philosophy of the board changed with respect to the compensation issues?

A. It could. It depends on what it changed to.

Q. Of course, if the board acted less independently than it is now, in your opinion, would your conclusions change?

A. Well, if you are saying if the board stops behaving in an appropriate manner, would I believe they are not operating appropriately anymore, then you are right, I would agree.

Q. So your opinion would change?

A. Could change.

Q. Could change? Now, prior to the preparation of your reports, you did not review board meeting minutes or compensation committee meeting minutes relating to compensation at Premera; is that correct?

A. That's correct.

Q. But you did review those materials before you prepared your prefiled testimony; is that correct?

A. No. I did not review minutes of the meetings.

Q. You never have reviewed the minutes of the meetings?

A. That's correct.

Q. And is that both for the compensation committee, as well as the board?
A. That's correct.
Q. But I do understand that you did interview members of the compensation committee?
A. That's correct, the head of the compensation committee.
Q. Mr. Fahey, as well as Ms. Jewell?
A. Correct.
Q. My understanding is also that Towers Perrin did not perform an independent analysis of the value of Premera officer benefits; is that correct?
A. That's correct.
Q. In fact, Towers Perrin relied upon the analysis performed by Premera's benefits consultant, Watson Wyatt, in that regard; is that correct?
A. That's correct.
Q. And that analysis involved Premera's executive retirement benefits, both the defined contribution, as well as the defined benefit supplemental retirement plans; is that correct?
A. That's correct.
Q. Did that involve also an evaluation of the change in control benefits?
A. I don't believe it did.

Q. Did Towers Perrin engage in an analysis of the value of the change in control benefits?
A. We didn't examine the value of the change in control benefits, however, we looked at the form of the change-in-control agreement.
Q. Would you agree with me that change in control benefits do have a value under certain circumstances?
A. Yes, they do.
Q. Am I correct in my understanding that Towers Perrin has not looked at how much Premera would have to pay out if Premera were acquired prior to conversion and the CEO and each of the executive vice-presidents and senior vice-presidents were either involuntarily terminated without cause or constructively terminated?
A. That's correct.
Q. Is it true that the -- that there are no change in control benefit enhancements proposed for post-conversion Premera during the three-year restrictions period?
A. I don't know.
Q. Do you know whether the change in control benefits could be impacted if there are increases in base salary?
A. Yes.
Q. They would be impacted?
A. Yes, they would.

Q. And they would go up?
A. Yes, they would.
Q. Except to the extent that stock options might be included, change in control benefits are not related to shareholder value, are they?
A. That's not correct.
Q. Why not?
A. We believe that the entire purpose of the change in control is to allow the executives, particularly the most senior executives that are affected by this, to make a decision based on shareholder value rather than their own careers. That's the purpose of the change in control agreement, to allow these executives to disassociate themselves from their own careers and make a decision regarding a potential change of control that's in the interest of the shareholders.
Q. But you -- at this point in time you have not valued how much the pay-out would be if Premera were to convert prior to conversion -- I am sorry, not conversion -- be acquired prior to conversion?
A. The value? No. But we have looked at the form, the multiples of compensation to determine whether or not they were competitive.
Q. Do you know how many Blue Cross/Blue Shield plans have converted from non-profit to for-profit and become

public companies that have remained independent post-conversion?
A. A dwindling number. No, I don't know exactly the number.
Q. Just Empire? Would Empire be the only one, and it has been converted? Just one?
A. No. I don't know the exact numbers.
Q. In connection with your review of Premera's compensation program, have you reviewed any reports that analyze the value of the total compensation program, including benefits, other than PricewaterhouseCoopers' report?
A. No, we haven't.
Q. Do you have any knowledge whether such a report, other than PricewaterhouseCoopers', has been prepared?
A. I assume that Watson-Wyatt's review of the nondirect benefits is one, and it could be added to ours and to Mercer's, and there would give you the total benefits. But I haven't seen the total.
Q. Have you seen the Watson Wyatt report?
A. No, I haven't.
Q. Do you know if it has been shared with the board?
A. I believe it has.
Q. Has Towers Perrin looked at and analyzed how much management and the directors will make -- how much more

money management and directors will make if Premera converts?

MR. KELLY: Objection, assumes facts not in evidence. Hypothetical. You can answer.

JUDGE FINKLE: Go ahead and answer.

A. Well, they won't make any more in my understanding, unless the stock price goes up sometime between grant and termination of the options. There is no intended change, as far as I know, to change the cash program.

So unless you believe that the options are some sort of guarantee, then I don't think you are going to make any more on the conversion.

MR. HAMJE: That's all I have at this time for Mr. Furniss. Thank you, Mr. Furniss.

THE WITNESS: You are welcome, Mr. Hamje.

CROSS-EXAMINATION

Q. I am Amy McCullough, here on behalf of the Alaska Intervenors. I just have a few questions for you.

To your knowledge, Premera has not committed to any limitations on its base salary for the two years following conversion; is that correct?

A. That's correct.

Q. And so there is no cap whatsoever on its ability to increase its base salary for its executives during those

two years; right?
A. Could you repeat the question.
Q. Sure. They haven't proposed any cap on increase in their executives' increase in base salary for those two years; is that correct?
A. I am not aware of a formal cap having been proposed.
Q. Okay. And an increase in base salary certainly increases the value of any -- or certainly of the change in control pay-outs; is that correct?
A. An increase in salary would increase the benefits payable, yes.
Q. So it has a multiplier effect; right?
A. That's correct.
Q. And, as I understand it, post-conversion, Premera's CEO Gubby Barlow, total compensation will jump as much as 50 percent, up to 2.24 million dollars; is that correct?
MR. HAMJE: Object, no foundation.
JUDGE FINKLE: Could you rephrase the question.
MS. McCULLOUGH: Sure.
JUDGE FINKLE: Eliminate the "as I understand it."
BY MS. McCULLOUGH:
Q. Do you know whether Mr. Barlow's total compensation

will increase as a result of the conversion?
A. Not to my knowledge, unless you believe in the stock option value. The only document that I have seen, which I believe is the one that you are referring to, is the Mercer proposal report, which there is a value assigned to the stock option.
Q. But the Mercer report also reflects his base salary will increase; is that correct?
A. I believe it does.
Q. Okay. Thank you. And would the board members' duties dramatically increase as a result of conversion?
A. In my opinion, they will.
Q. And how dramatically will they increase?
A. They will have a great deal more public scrutiny, they will certainly be open to shareholder suits. They now have a constituency that they never had before, which is the shareholders.

They will now formally be subject to all the rules Sarbanes-Oxley, depending on where the shares are listed. They may have additional restraints on their activities from the exchanges.
Q. So the skillset that's required of these board members to run a non-profit, may well be different than the skillset required to run a for-profit; is that correct?

A. No, I don't believe so. I think there are enough skills already in place on the board of board members with public company experience. So I don't think --
Q. You mean, specifically Premera's board?
A. Correct.
Q. But, in general terms, the skillset that's required to be on the board of a non -- of a non-profit may vary from the skillset required to be on the for-profit; is that right?
A. The basic skillset to run the health insurance company is the same. We now have additional duties if they are public. That's my feeling.
Q. And the board members' compensation will increase from $44,500 to $119,500; is that correct?
A. If you believe in the value set on the stock options by Black-Scholes.
Q. For the board members?
A. I believe so. I haven't looked at the board member -- I have only looked at the executive compensation. It was my understanding that they would be receiving options also, but I may be in error.
Q. In either your original or your supplemental report, you didn't assess the role that executive compensation played in its position to pursue conversion, did you?
A. No, I did not.

MS. McCULLOUGH: Thank you. No further questions.

REDIRECT EXAMINATION

BY MR. KELLY:

Q. Just a few, if I may, to just clarify something I think you said in your direct testimony. You were talking about benchmarking, and you said there was a peer group, you mentioned public and non-public.

Now, Premera is a non-profit, how does the peer group -- what's the -- the peer group includes both for-profit and non-profits, as well as public and non-public?

A. Yes, it does.

Q. Okay. Mr. Hamje asked you about the fact that there is stock options, but there is also still a long-term cash portion of compensation?

A. That's correct. Yes.

Q. And what is the reason for continuing to have a long-term cash portion, in addition to having a stock option portion?

A. We believe it is necessary to highlight the particular performance measures that will lead to increase shareholder value.

Q. Now, the next area he talked about was base salary.

Currently, the -- who sets the base salary for the executives?
A. The compensation committee.
Q. Okay. Do they have data from Mercer Consulting on what base salaries are in the peer group?
A. Yes.
Q. Okay. And is there any reason to think that the compensation committee would not continue to use base -- use the peer group data to set base salary?
A. No. PWC has agreed with us that their current salaries are at market, that they have had perhaps higher than market salary increases in the past but the current salaries are at market.

So there is no reason, as far as I know, that salaries would increase at an above-market rate as that data is readily available.

Q. As I understand from what Mr. Hamje was saying, Mr. Nemerov is saying, well, there ought to be some fixed percentage increase on base salary. In your view, who should be making that decision about whether there is any increase in the base salary, and if so, what percent?
A. In every client I work for, the compensation committee decides this based on information that's available that's determined by expectations.

If you rely on the market, you are always lagging it by a year. And I am not aware of any organization whose salaries are limited by salary increases or limited by an external authority.

Q. Mr. Hamje also asked about benefits, as opposed to compensation -- direct cash or other compensation of benefits, that would accrue with retirement and so forth.

There is a link, is there not, there is an input from the amount of the base salary that affects how much your benefits --

A. That's correct.

Q. Is that common everywhere?

A. Well, everywhere. Most benefits have some relationship to salary.

Q. Now, does the board -- or should the board of the compensation committee take into account the fact that if they are going to give a percentage increase to base salary, one of the consequences is that there will be some increase in benefits?

A. That's correct. Most boards I know do that.

Q. Now, there was a question about the composition of the board post-conversion and specifically the compensation committee.

Does the compensation assurances that we referred

to earlier, Exhibit E-8 from the Amended Form A, are one of those assurances -- do one of those assurances deal with adding another board member to the board and also to the compensation committee?

A. That's my understanding, that the foundations will be able to have input to that addition.

Q. To be able to nominate one?

A. Yes.

Q. And that individual would serve on the board and also be in the compensation committee?

A. That's my understanding.

Q. Would that be, in your view, an additional safeguard as to the compensation committee continuing to make appropriate decisions --

MR. HAMJE: Objection, leading.

JUDGE FINKLE: I am going to allow that one.

A. Yes, that's my understanding.

Q. Now I would like to -- there was some questions about value of the benefits, and that's trying to figure out if you retire on this year what the benefits will be. Is that your description of value and benefits?

A. Yes.

Q. And that's been done by -- to your understanding, by whom?

A. I understand it -- well, it has certainly been done

by PWC in their report. I also understand it was done by Watson Wyatt. I also understand that PWC raised no objections to the competitiveness of the level of benefits.

Q. Okay. Now, there has been some discussion about change in control, and you talked about looking at the form of the agreements. First of all, the change in control provisions that we are talking about cover both the CEO in Premera and certainly the top executives?

A. That's correct.

Q. Fairly high level, what is the reason -- you described the reason for -- or one of the reasons for having a change in control provision, and you said it is to disassociate the executive from their career interest to help them make a decision. Could you elaborate on that a little bit.

A. Yes. The original purpose, and to a great extent the present purpose, is to allow the executives to take an objective viewpoint of merger or sale opportunities and look at the interest of the shareholders and the other constituents, and be assured that personal -- while a career is still obviously at risk -- the executive will receive several years of compensation, during which time he can find a new job. That's the purpose of the change in control.

The change in control agreement that Premera has has an additional feature, and it encourages the executive to stay in place for a minimum of a year.
Q. How does it do that?
A. It has a clause that allows the executives to "walk away," quote, that's a change in control term, to walk away one year following a change of control during a 30-month window period, if he or she decides that the new owner is not -- these new career opportunities are not what he has in mind or she.
Q. I think you just said 30-month period.
A. It is a 30-day period, one year after the change in control.
Q. And is the idea there that the executive could stay on to help the company make a transition, but still be able to have some compensation if he or she decides to leave after that one year --
MR. HAMJE: Objection, leading.
JUDGE FINKLE: Sustained.
BY MR. KELLY:
Q. Could you give us a nutshell what the impact is of that one year.
A. If the executive chooses to leave after one year, then he or she receives half of the normal benefit.
Q. And now that -- you just explained -- used the term

half of the normal benefit. How does that provision of one-half of the benefit compare with other change in control provisions that you have seen in the industry?
A. Well, the Premera change in control agreement, except for that feature, is a very standard agreement. It provides for what's called constructive termination, which means the executive in the acquired company, if his or her job is diminished, if the compensation is diminished, and any number of other clauses, then the executive can claim he or she has been constructively terminated and receive full benefits and that can happen immediately.
Q. But if it is just the normal payout and after a year it isn't working out, a person wants to leave, how much do they get?
A. Well, if their original coverage is two times salary plus bonus, they would get one times salary plus bonus.
Q. In other words, one half the normal --
A. One half the normal and a year to find a new job.
Q. As I understand it, there are two general reasons for change in control in the Premera case. One, is to help the executives make an independent decision about, gee, should we enter into a merger, even though it may mean that I am going to lose my job --
JUDGE FINKLE: I am sorry, but I know this

is going to be leading. You need to --
BY MR. KELLY:
Q. Fair enough. Could you just summarize for us what you see as the two --
A. You put it very well, counsel.
Q. It is just my fear of limits of time. Could you tell us, from your -- in a summary view then, what are the two types of benefits that Premera's change in control --
A. The change in control is set up to provide compensation for the executive during the period that he is looking for another job. And the purpose of that is to allow him to look at an offer, participate in an offer evaluation for -- to acquire the company, and it will allow the executive to focus more on the shareholder than on his career.

The second feature of the Premera plan is this encouragement to stay for one year during the transition period, which allows the acquirer time to decide whether he wants the executive enough to make an attractive package.
Q. Now, prior to making this proposal for a conversion, was there any agreement made by the executives as to whether the event of conversion itself would constitute a triggering event under the change-in-control

agreement?
A. Yes, there was. And the executives -- it was agreed that the conversion would not constitute a change in control, even though technically it is.
Q. And then the -- going back to one area on stock options, what is the term that's used for the initial price at which the -- at the time that the stock option was granted?
A. The strike price is usually -- it is the fair market value in this case at the time it is granted.
Q. So whatever it is at the time of the grant, that is called the stock price -- strike price?
A. Strike price or the exercise price.
Q. And then how is the sale price determined when the option is exercised?
A. Once it is vested, the executive then can choose when to exercise and if the stock price/strike price is 20 dollars and some day it is 21 dollars, the option can be exercised for a gain of one dollar. If the option holder wants to wait longer and hopefully it will go up to 40 dollars, then the gain is 20 dollars.
Q. And without trying to ask a leading question, what -- when you do that exercise the price is at 25 dollars, the strike price is 20 dollars, does the executive have to pay the 20 dollars to get the stock

that's now worth 25 dollars?
A. He can pay the price and then hold the stock that he has owned, all of it, or he can exercise what's called a cashless exercise and simply get the spread.
Q. But in any event, the gain to the executive, he or she, is what in that example of 20 and 25?
A. It is the spread, and that's the 5 dollars.
MR. KELLY: That's all I have. Thank you.
MR. HAMJE: We have no further questions. Thank you.
MS. McCULLOUGH: I just have a couple.

RECROSS-EXAMINATION

BY MS. McCULLOUGH:
Q. It is unusual for positions below that of CEO to be provided walk-away provisions; right?
A. Yes.
Q. And there is nothing to prevent the board from changing its compensation philosophy from one of -- targeting the median to one of leading the market; is that correct?
A. Nothing to prevent? There is the board's own philosophy, there is the board's own ethics, there is the potential lawsuit.
Q. It is up to the board to decide whether it wants to

target the market, take some other position like a lead leg of the market or to lead the market; is that right?
A. Yes, you are correct.
Q. And if the board were to change its compensation philosophy to leading the market, the executive stands to have a base salary increase; is that correct?
A. No, not necessarily.
Q. So if they are now at the median -- I am sorry, let me be clearer.

If their base salary is currently at the median, and the board determines that its philosophy should be leading the market, where should their base salary fall within the range?
A. It depends on how they intend to lead the market. Some companies will lead the market through incentive plans and grant larger than market incentives. Some will -- long-term incentives, mega grants of stock options.

There is any number of ways to lead the market. The trend these days is to lead it through performance-related pieces, so that the performance has to be there to pay out.
Q. Okay. So it would lead the market in terms of increasing the base salaries, where would those base salaries have to be approximately?

A. Well, I looked at the peer groups' base salary increases for the past two years and they are six to nine percent. This is the peer group that everyone has agreed to. So that's six to nine percent a year. I have no notion that Premera intends to raise salaries at anything like that.

MS. McCULLOUGH: Okay. Thank you. No further questions.

MR. KELLY: Nothing further.

MR. HAMJE: Nothing further.

EXAMINATION

BY COMMISSIONER KREIDLER:

Q. Mr. Furniss, you would be I presume what would be considered a benefits consultant?

A. No, sir. I am a compensation consultant. In our world, it is quite different.

Q. Compensation consultant? I am curious as -- when you refer to the peer group, if you could define a little bit more for me what you mean by peer group when you are doing -- putting together your analysis?

A. Yes, sir. We -- the peer group, broadly defined, would include the entire healthcare industry from survey data, which includes for-profit/not-for-profit, the mixture that we talked about earlier, and the surveys

usually have at least 20 or 30 companies in them.

We supplement that with specific companies, and those are specific public companies whose compensation data is available and whose size allows us to place the client, in this case Premera, at the median. So we have some large ones and some small ones.

Q. How much, in that evaluation or analysis, is based on what exists in the State of Washington as opposed to regional or national?

A. In the case of major -- in the case of senior executives and companies Premera's size, we use the national peer group. We assume that the executives could be recruited from anywhere in the country and lost anywhere in the country. So we would not narrow it -- in our philosophy, we wouldn't narrow it to the State of Washington.

Q. Is there any reason to consider Washington somewhat different, different in the sense that you do not have the degree of for-profit public company competition in the State of Washington, as opposed to what would be experienced perhaps nationally?

A. We wouldn't. In our viewpoint, there is a market for executives and there is a market for insurance products, and we are talking about the market for executives. So you are competing potentially against

the -- as I have learned in the hearings earlier, you have got potential competition from anywhere in the country. But we are not pricing the product -- we are not pricing the market for products, it is for executives, and we believe they could come in from anywhere.

Q. Do you take a look at the -- as a part of the analysis, the compensation in the State of Washington with other non-profits, and in part making that analysis as to the appropriateness of senior management compensation?

A. To the extent they fall -- to the extent they participate in the surveys, we would. The reason, we would like to have their compensation, but the CEO -- his compensation is not identified. So we are not able to determine the CEO.

Q. I am curious, who hires a benefits consultant? Is that hired by the compensation committee of the board or is it hired by management?

A. Traditionally, it has been hired by management. And, increasingly, we are hired by the board. We work with management, but we are answerable to the board and we are answerable directly to the chairman of the compensation committee.

Q. In the case of Premera, has that hiring been done by

the board or by management?
A. We were selected by or identified by Premera's outside counsel. We interviewed the senior management and we interviewed the board, and any one of them could have vetoed us.
Q. Who decides who gets interviewed, is that senior management or is that done by the board?
A. We told counsel who we wanted to interview and interviewed the chairman of the compensation committee and any other members of the board that had an input we wanted -- we identified the senior executives we wanted to talk --
Q. Pardon me, I am thinking about Towers Perrin or Mercer or any of the other benefits consultants or compensation consultants that would be selected for interview by the board, or in this case, by management if that decision is, so to speak, pre-made by management, as opposed to the compensation committee or the board?
A. I assume -- this is a very transparent organization, the board and the management seem to be -- neither one of them is doing things that the others aren't aware of.
So we are assuming -- at least I assume, and I may be incorrect -- that the board concurred that Towers Perrin was a reasonable choice.

Q. But ultimately the decision as to who was hired was not one that was made by the compensation committee of the board; is that correct?
A. I don't know. I don't know who made the final decision.
Q. What are the chances if management is making it then you have a compensation consultant who is coming in with estimates that senior management didn't like from the standpoint of their analysis of being selected once more?
A. We made it very clear that if we didn't believe that the compensation of Premera was consistent with the philosophy, then we wouldn't proceed at this time but we would send the bill anyway.

We are not here only because we have decided they are paid at market. But both our assessment, PWC's assessment and Mercer's assessment are that the post-conversion compensation is reasonable, so we are comfortable with that.
Q. I am curious, relative to health carriers in particular, I think it is fair to say that historically it was largely derived for not-for-profit in the health insurance market, and I say that historically. It is obvious that that's going through some evolutionary changes, by the fact that we are here today.

A. Yes.
Q. And I am curious, is there a difference in how compensation would be derived or benefits for compensation would be derived in the healthcare field, as opposed to what might be considered corporate America?
A. I don't believe so. Ultimately, if we are talking about either for-profit or not-for-profit companies, health insurance companies and corporate America alike, have to earn an acceptable return on the capital that's entrusted to them. We are talking about capital-intensive business here. And whether you are for-profit or not-for-profit, you have to earn an acceptable return or you go out of business. How you earn the return differs from the health insurance industry dramatically, which is why we limit our market pricing to the health insurance business. We don't look at general industry for very many positions but they are a very specific set of skills as you know. But we believe that the market for health insurance companies is that the pay is pretty much consistent. And we have identified the market, and we believe that Premera is right at it.
Q. So even though the State of Washington might be still somewhat different to what some of the pressures

that are taking place nationally relative to current -- in the current market between not-for-profit and public companies, in essence, your compensation analysis really doesn't take that into account. It is much more looking at it from a national perspective, as opposed to how we exist here in the State of Washington and have functioned historically?

A. That's correct. We believe the skills you need to compete in the State of Washington are the same skills you need to compete everywhere -- Premera needs to compete everywhere. That's why we use a national market.

COMMISSIONER KREIDLER: Thank you, very much.

THE WITNESS: You are welcome.

FURTHER REDIRECT EXAMINATION

BY MR. KELLY:

Q. I just had a couple of follow up questions. Relating to this question of payments or executive -- or compensation for executives that Premera is trying to retain or attract in Washington, what is your understanding of, first of all, whether any of the Premera current executives have come -- were out of state when they were hired to come to Premera?

A. I understand that quite a number of them were out of state when they were hired to come here. And further, that the majority of the senior management team has worked, at one time or another, at a for-profit company.
Q. Would Ms. Donigan be an example of a person who has worked for Blue, I think she said, and for-profit CIGNA?
A. And CIGNA.
Q. And where was she located before she came here?
A. New York City, of all places.
Q. Now, in terms of -- you talked about that you didn't know the compensation of the CEO of Regence. When you say that, are you referring to Regence Blue Shield of Washington, subsidiary, or the holding company, which I think is called Regence Holding Company?
A. We are referring to the holding company. The analysis done to Mr. Barlow would be the holding company, not the head of Washington, that would be a regional job.
Q. And Regence Holding Company doesn't make public what its executives' compensation --
A. That's my understanding. We couldn't find it.
Q. And I think when you and the Commissioner were questioning and answering, you may have been talking about how you got hired and what you were going to do. And I am not sure, the Commissioner may have been asking

a little bit more about in general what happens with Premera's regular compensation consultants, Mercer's. So let me ask you a few questions along that line.

Is it true that Mercer answers directly to Premera's compensation committee?

A. My understanding.

Q. And it is your understanding that that committee has the fire -- whatever -- hire somebody else authority --

A. That's my understanding.

MR. KELLY: That's all we have. Thank you.

MR. HAMJE: I just have a couple of follow-ups along the line that Mr. Kelly started.

FURTHER RECROSS EXAMINATION

BY MR. HAMJE:

Q. With respect to Mercer, do you know whether or not management retained Mercer originally, or whether the compensation committee or the board retained Mercer?

A. I don't know.

MR. HAMJE: That's all I have. Thank you.

MS. McCULLOUGH: No questions.

MR. KELLY: Nothing further. May this witness be excused?

JUDGE FINKLE: Please, step down.

MR. KELLY: Commissioner, if we could -- we

are going to turn off the video camera, we appreciate being permitted to videotape this, and we will break it down during the morning break.

JUDGE FINKLE: Which is now.

(Morning recess.)

JUDGE FINKLE: Let's resume.

MS. EMERSON: Premera calls Brian Ancell.

BRIAN ANCELL, having been first duly sworn by the Judge, testified as follows:

DIRECT EXAMINATION

BY MS. EMERSON:

Q. Good morning, Mr. Ancell. For the record, my name is Ramona Emerson, representing Premera Blue Cross. Can you please state your name and spell your last name for the record, please.

A. Yes, Brian Ancell, A-N-C-E-L-L.

Q. Can you tell us who your employer is and what your position is with that employer?

A. Yes. Premera Blue Cross, and I am executive vice-president of healthcare services and strategic development.

Q. Can you tell us what your duties are as executive vice-president at Premera?
A. Yes, I am responsible for provider network development, provider relationships, our care facilitation programs, the company special products and our strategic development.
Q. Can you please give the Commissioner an overview of your professional background prior to your current position at Premera?
A. Yes. From 1988 to 1990 I worked with Coopers & Lybrand in Boise, Idaho, and obtained my CPA designation at that time.

From 1992 to 1996, I worked with Deloitte Consulting here in Seattle. And in 1996 I joined Premera Blue Cross, initially as senior vice-president of marketing and strategic development. In 1997, I became senior vice-president of operations. And then in January of 2000, I took on my current position.

Q. Can you describe for us, please, your educational background since high school.
A. Yes. I have a degree in business administration from Boise State University in Boise, Idaho. And I have a master's in business administration from Harvard University.
Q. Are you a member of any professional organizations?

A. Yes. I am a member of the American Institute of Certified Public Accountants.
Q. And can you tell us -- now that your prefiled direct and prefiled responsive testimonies have been served and filed in this proceeding, do you adopt that testimony?
A. Yes, I do.
MS. McCULLOUGH: Mr. Ancell's prefiled direct and prefiled responsive testimony have been marked a hearing Exhibits P-36 and P-37 respectively. With the adoption of that testimony, Premera now moves to admit those exhibits.
MS. DeLEON: No objection.
MR. COOPERSMITH: No objection.
JUDGE FINKLE: Admitted.
BY MS. EMERSON:
Q. Mr. Ancell, can you tell us a little bit about Premera's provider network? First of all, how broad are those networks?
A. I will start by saying Premera's provider networks are extremely important to us, to making sure we have a good network to serve our members.
We have, I believe, the broadest networks in the state. We have 16,000 physicians in the network. We have another 4,000 other professionals, for a total of -- as Mr. Barlow indicated in his testimony -- of

20,0000 professional practitioners. We also have approximately a hundred hospitals. And we are the only health plan that provides a network in every county of the state. Which that, by the way, is a significant competitive advantage for us in the marketplace.

Q. You mentioned that these provider networks are very important to Premera, can you tell us why?

A. We -- our members want access to a broad range of providers. They want to have many choices when selecting a provider.

It also is very important to us in terms of competitiveness for selling our products. Brokers, when they select a health plan or recommend a health plan to a client, there is something called disruption analysis. And they compare one health plan's network to another to identify how many members would have to move their physician if they moved health plans.

So by having a broad network it reduces the disruption that would occur for an employee group should members move. So the broader our network, the better we perform in the disruption analysis. But it is very important to us, not only through member choice aspect, but from competitive aspects in the marketplace.

Q. Is a stable network important to Premera?

A. Yes. Stable networks are very important to Premera.

Our members want to be able to rely on the fact that the providers they have are going to be in the network on an ongoing basis. And they are quite concerned if it appears there might be a risk of a provider leaving the network.

In fact, over the last several years, Premera has had very stable networks. We have had less than a one percent turnover rate, and that includes turnover from all reasons, including physicians who are retiring.

Q. What does the company do to ensure that it can offer both broad and stable networks?

A. Well, the single most important thing that we can do is to make sure that we have positive provider relationships. And so we work very hard at Premera, in fact, we consider it one of our strategic objectives to ensure that we have strong relationships with the physicians and hospital community and the other providers.

And we do that by considering a number of factors. One very important factor is ensuring we have appropriate market reimbursement. If we don't provide appropriate market reimbursement, we are not going to be seen as competitive in the market and won't have positive relationships.

Another is making sure we have good administrative

procedures and are easy to do business with.

And finally, very important, is good communication, in both ways. Not only our communication about what Premera is doing, but listening to the physician community about what their needs are.

Q. Can you tell us a little bit about Premera's relations with providers? First of all, can you characterize the company's commitment to improving relations with providers?

A. Yes. We have a very strong commitment to improving relations. In fact, one of the first things Mr. Barlow did when he became president of Premera and asked me to take on my new responsibilities was meet with me and said, "Brian, we want Premera to be a doctor-friendly organization. One of our competitive advantages can be that we are local and we can build those strong relationships."

Q. If I can stop you there for a moment, when did that occur?

A. That was in January of 2000.

Q. Can you tell us how Premera seeks to maintain positive relationships with its providers?

A. Yes. We approach it a couple of different ways, because the market of providers have a couple of different needs. And so, for example, large

multi-specialty clinics have different needs than smaller, individual providers.

So with large multi-specialty clinics, for example, we will work one-on-one with their administrative staff to identify what their problems and challenges are. We also have something called a clinic advisory board, which the heads of many of the large clinics in the state participate in, and we work jointly on communicating back and forth and sharing problems, and also the clinics, at the time they were formed, to share best practices.

For individual providers, we have a number of similar venues that we communicate and share information. We have something called regional advisory physician panels, and these are groups of physicians in different areas of the state that meet periodically to sit down, and we communicate out initiatives that we are doing, and provide an opportunity for them to share information back.

And then finally, we also have forums for office managers, for the smaller physicians, where they can come and share with us what did they find frustrating about the administrative problems they might be having with Premera. And then we will also interact individually with physicians if they have needs to

contact us.
Q. Along those lines, does Premera have dedicated staff available to assist providers?
A. Yes, we do. We have a significant amount of staff. First off, we have a dedicated customer service team to answer provider questions. So the calls go directly to that team.

We also have provider network executives and provider network associates, and they are trained professionals who are targeted at serving specific needs of providers that a customer service member may not be able to handle.

We also, in the clinical side, have medical directors and pharmacists that will sit down and work with providers on clinical issues.

And finally we have our management team is very engaged in communicating with providers and trying to share information back and forth by going out and meeting providers individually or working with the associations.
Q. Do the company's medical directors play any role in the area of assisting providers?
A. Yes. Our medical directors are very important in building the relationships with the providers, because they can speak to them on a peer-to-peer basis. Our

medical directors all have experience in practicing. And so actually having practice experience is important in that relationship.

Our philosophy at Premera, however, is that the physician ultimately makes the decision on care for the patient. Our role is to facilitate it, not to make the decisions, and I believe Dr. Chauhan will discuss that in his testimony.

Q. Has Premera provided any leadership in that area of collaborating with providers, doing anything to make administration easier for providers?

A. Yes. I believe Premera has been a leader, in fact, in the market for doing that. We are founding members of the healthcare forum and as part of that have worked extensively on the administrate simplification work group, which is a group which is targeted with trying to identify ways to simplify administration.

And we have played a lead role in uniform credentialing application development. Another significant initiative that we played the leadership role on was the development of one health port, and that is a single sign-on capability for a provider group. So a provider group doesn't have to have separate Internet sign-on for each health plan, they can log on once and access any health plan that's subscribed with one health

port.
Q. Does the company provide any other technology solutions for providers?
A. Yes. We have worked extensively over the last several years to provide technology solutions for providers. You have heard about the investment in dimensions we made, and that is a significant step forward in duplication for our administration, going from six systems to one system will make it much easier to make sure we have simple, clear processes.
And one of the most important benefits has been our provider portal, which is our on-line website, secure website, that physicians can go on-line and check benefit eligibility, they can check claim status, they can check benefits from the member in their office, and it makes it much easier for them to be able to do a large amount of review quickly, rather than going through a customer service person.
Q. How do you characterize the results of Premera's efforts to work with providers, as you have described, since the year 2000?
A. I think we have been very successful, and we have been pleased with the results. In terms of the clinic relationship, we have been recognized -- in 2003 we were asked to go present to the American Medical Group

Association -- not only their national conference, which we did in conjunction with Wenatchee Valley Clinic -- but also to their western regional conference in conjunction with the Rockwell Clinic, and we have been recognized by them as a model of what collaboration between health plans and providers can look like.

In terms of the individual physicians, Dr. Gollhofer provided information on our physician satisfaction survey. And we not only rate it very well, but we have been improving. We had overall, physicians 75 percent said that we are better or much better than other health plans to work with. In terms of provider relations, 69 percent said we are better or much better. And in terms of contracting, 58 percent said we are better or much better than other health plans.

Q. Could you please turn to Exhibit P-218.

A. Yes, I have it.

MR. COOPERSMITH: We object, Your Honor. Your Honor, the Intervenors object to the use of Exhibit P-218. Opposing counsel just provided us this exhibit over the 10:30 break a couple of minutes ago. And it is the Intervenors' understanding that, other than for impeachment purposes, exhibits had to be disclosed and submitted in advance in accordance with the prehearing schedule set by Your Honor.

MS. EMERSON: Your Honor, Exhibit P-218 is the results of the 2003 physician satisfaction survey that was referenced in Dr. Gollhofer's testimony.

As you may recall, at that time we did move and the summary of that survey was admitted into evidence at the time. Mr. Coopersmith, however, made a request on the record for the introduction of the underlying data supporting the survey. When we had the break yesterday we went back to our offices, we collected the information, and I provided the information to Mr. Coopersmith just as soon as I saw him in the hearing room this morning. My first opportunity to provide him with the information was before the break, but in time for him to review it before Mr. Ancell's testimony today.

MR. COOPERSMITH: Your Honor, the Intervenors reject the characterization of the previous exhibit as a summary of the survey, as you will hear on cross-examination. Turning to Exhibit 218, the Intervenors did in fact request the underlying data, but that doesn't mean that we agree that this data, given to us just minutes ago, should be used in this testimony by this witness. We obviously have had no time to review it.

And again, counsel had the same opportunity

that all the other parties did to comply with the deadline for this admission of exhibits to produce in the hearing.

JUDGE FINKLE: I believe that submission of underlying data is on a different footing than other material. I will permit the admission into evidence of 218, but I do want you to have the opportunity -- not while you are trying to focus on your examination -- to review it and to do cross based on the study itself.

So at least through the noon hour -- I assume the witness will continue to be available. How long do you think it will take on direct? We have got -- is it going to be your 45-minute type of direct?

MS. EMERSON: I believe, Your Honor, it is right around 30 minutes.

JUDGE FINKLE: Okay.

MR. COOPERSMITH: Your Honor, I appreciate the Bench's ruling of course. I don't want to sound immodest, but I think I am probably the least-qualified person in this room to assess the underlying data.

However, the firm does have personnel who can do that for us, but can't do it for us now. So we would like, if the Court wishes to allow this witness this testimony, we would like to have the opportunity to bring him back then if necessary based on our analysis

of this.

JUDGE FINKLE: Why don't you do your cross on all other subjects, and then you can decide whether you need a further opportunity. If you do, I will give it to you.

MR. COOPERSMITH: Thank you, Your Honor.

JUDGE FINKLE: Go ahead.

BY MS. EMERSON:

Q. Mr. Ancell, you may recall that Commissioner Kreidler had a couple questions about how the physician survey was created and had some questions about whether the information of the identities of the physicians that participated were -- remained anonymous. Can you provide some background on the survey, please?

A. Sure. The survey is a survey we have done for the last several years to get information on how our physician satisfaction is doing. It was conducted by Morpace, which is an independent group. We provided them with a file of all of our contractor providers. From that, they selected a random sample of just under 5,000 providers and mailed out a letter giving them the opportunity to respond to the survey, either on-line or by phone.

The first 500 were offered a hundred dollar honorarium for their time to do that. Others could

respond, but they were not offered the honorarium because the consulting firm said that was the appropriate level to be significant in our market.

They were informed that it was Premera that sponsored the survey. They also were informed that any data would not be connected with their names individually, that Premera would not receive that information, and we have not received that information. So they knew in advance we wouldn't receive it, and we have not received data connected to individual physicians' names.

Q. Mr. Ancell, in light of the feedback that Premera received in the form of the formal survey and the other initiatives and dealings that Premera has had with providers, how do you respond to the Intervenor witnesses who criticized Premera's dealings and Premera's relationships with providers?

A. Well, I was shocked, and of course disappointed, because we have worked very hard to improve relationships, not only with providers in general, but with the medical and hospital association over time.

We talked about -- or Dr. Gollhofer talked about Dr. Castiglia going to meet with them, and that was part of a focused effort that the company was making to get out and meet the heads of the associations, as well as

the leaders of hospitals and clinics, and share with them about how we wanted to work better with them.

During that same time period, I also contacted Dr. Collins and had the opportunity to have dinner with him and talk with him about what we wanted to do and solicit feedback from him.

From time to time I have had interaction with Dr. Collins and he is -- knows how to contact me. So I would have hoped, had he had these kinds of concerns, he would have contacted me and shared the concerns with me so we would have the opportunity to work with him.

And I am more than willing now to continue to work on those concerns with him, or any other provider in the state that would like us to work with them.

Q. And to date, Dr. Collins has not contacted you directly to share specific concerns that he has about his own experience with Premera?

A. The first meeting we had he did share some concerns with me, and we tried to follow up on those concerns at that time. But that was a couple of years ago now, and I have not recently received concerns from him about his practice in particular.

We also have a medical director designated for his practice that would be available to sit down and work on any concerns they might have.

Q. What is the status of Premera's efforts to work with providers today?
A. We continue to view it as a key strategic aspect of our company, that we believe broad networks and strong relationships are very important, and are committed to working with any providers association or individual providers or provider groups that would like to work with Premera.
Q. You also mentioned that market-appropriate compensation to providers is important to maintaining Premera's provider networks. What do you mean by that?
A. Well, we believe that we need to make sure we are providing not the bare minimum reimbursement in terms of our standard fee schedule, but a level of compensation that's competitive, given what others are paying in the market, but also at a level that providers can meet the cost incurred of treating Premera's patients.
Q. What have been the recent provider rate increases to Premera's standard fee schedules?
A. In the -- since 1999 to 2003, we have increased our standard fee schedule 20 percent statewide, which is an average of about 4.7 percent a year, and that's pretty much evenly split between eastern and western Washington, the eastern Washington being just slightly higher, a little over 21 percent.

Q. I would like to ask you some questions now about how Premera deals with rising healthcare trends. Is there an illustrative exhibit that will help you with this testimony?
A. Yes, there is.
Q. Can you please take a look at exhibit -- it is P-90 at page 12.
A. I have it.
Q. Mr. Ancell, can you describe for us Premera's approach to dealing with healthcare trends?
A. Sure. Healthcare costs -- I think people are probably familiar, in fact, they have been increasing at about 15 percent per year for the last several years, and that is a significant problem for the purchasers of commercial health insurance, that it is unsustainable for us to continue to increase at that rate.

What Premera's role really is is one of providing a balance in the marketplace. As the exhibit illustrates, we have very specific needs that our members demand from us. They want to have lower premiums, to have premiums not going up at the rate that they have been increasing.

At the same time, however, they want to be able to have a broad benefit package and broad networks so they can, as I mentioned before, see the physicians that they want to go to.

And they want to have simple administration, make it easy -- they want Premera investing in the infrastructure that makes it easier for them to do business with us.

On the balance to that, providers are demanding rate increases, and I would say they have some very challenging issues in their practices. One, Medicare and Medicaid significantly underfunds physician practices in this state, and that puts a burden on their ability to remain financially viable. And so that continues to put pressure on what they would like to receive in terms of compensation from Premera.

Also, malpractice costs have been rising dramatically and that puts additional pressure. So there is real pressures out in the market that are driving up physicians' costs.

And then also they want administrative simplification. They want us to make it easier for them to do business with us.

So Premera really sits in a role of trying to appropriately strike a balance between those two needs, and it is a challenging thing to do. And we do that in terms of our network through trying to maintain appropriate contracts with a broad set of providers, but also keep rate increases at a level which is affordable

for our members.
Q. And we have heard some testimony about Premera's care facilitation programs. How do they fit into this framework that you have described?
A. Care facilitation is a tool that helps us target managing costs of the most expensive members. Six percent of our members drive 60 percent of our healthcare costs.

So what we attempt to do with our care facilitation programs is tailor programs to those members that can benefit most from the program, and it is an important part of our program. First, as I said, the doctor always has the ultimate decision on care. The second is that we do member satisfaction surveys to make sure that we are not putting programs in place that members are seeing as intrusive or negative. We also do physician satisfaction surveys to see how the physicians are benefiting from our programs, and we do quality measures to make sure that the quality of care is never -- that we are actually improving quality of care, rather than reducing it with the programs.

And what we found in doing this targeted support from nurses or from our disease management programs, which Dr. Chauhan will discuss, we actually save between four to five dollars in medical costs for every one

dollar we invest in the program.
Q. Can you give us an example from the case management area?
A. Sure. I had the opportunity to sit down with one of our case management nurses and listen to her talk about some of the patients she worked with. And one she described as a young man, because of his condition, would have been in the hospital on an ongoing basis, without the hope of going home.

She was able to work with the family to make sure that everything was set up at home to provide care for that -- this young man, including 24-hour, around the clock, nursing services, which is something they would not have received in the hospital. In the hospital there are -- nurses are taking care of many patients. So he was receiving focused, 24-hour nursing treatment.

And it actually saved -- it saved, I believe in order of magnitude in this one case, $70,000 a month, and the patient is at home with his family, rather than being in the hospital. So that's an example of the kinds of things case management can do.
Q. Some of the Intervenor witnesses have said that Premera has too much leverage with provider contracting, and that it negotiates on a take-it-or-leave-it basis. What's your response to those assertions?

A. I do not believe that's true. I believe we work with physicians in the best interest of our patients. We have, as I said, 16,000 contracted physicians. It is not realistic for us to negotiate individual contracts with each of those physicians. And so what we try and do is set a fee schedule that will work for the vast majority of physicians.

In cases where we do get a request for a non-standard contract, we consider a number of factors. We consider what's the reason the physician is asking for it? Is there a financial need from their practice that is driving the request? We consider does the physician have unique services or type of care that they provide? We consider are there other options in the market for our member? How robust is the market availability in that area?

And then finally we consider the rate of increase they are asking and the impact that would have on member premiums. Because, as I said before, it doesn't serve our members if we continue to rise -- have healthcare cost increases for insurance they can't afford anymore.

Q. One of the Intervenor witnesses for the Washington State Hospital Association suggested in prefile testimony that private health plans need to keep reimbursements high to offset narrow hospital margins.

What's your response to that?
A. Well, I think -- a couple of things. One was my rebuttal testimony, and I did provide some information that shared that, while there are hospitals in the state that are struggling financially, there is also hospitals in the state that are doing quite well financially.

I think the highest margin in there, which is 2002, is 22.6 operating margin, which is a significant operating margin. Many of them were at or above the targets that I have heard the hospital associations say the four to five percent target.

I put that in there not to demonstrate all hospitals are financially viable, but to say that there are some in the market that are. And that we need to understand that you can't take necessarily a broad brush approach. You need to understand specifically by market what are the needs of the market.

The other thing is that they are asking us to support Medicare and Medicaid, and we cannot continue to ask our subscribers to increase -- today it is true that we subsidize those programs. But there has to be a limit to which we subsidize those programs, because every time we increase our premiums, more people can't buy insurance, and that's what happens if we continue to subsidize those programs.

Q. The hospital margin data that you referenced is being included in your prefile testimony, was that from the Washington State Department of Health?
A. Yes.
MS. EMERSON: At this time, we would move to admit Exhibit P-39, which is the hospital operating margin data from the Washington State Department of Health.
MS. DeLEON: No objection.
MR. COOPERSMITH: No objection, Your Honor.
JUDGE FINKLE: Admitted.
Q. Mr. Ancell, a final area of inquiry, does Premera's approach to contracting with providers change depending on the geographic location of the provider within the State of Washington?
A. No, it doesn't. We look at the factors I mentioned previously.
Q. Are provider reimbursement levels, or the contracting process that you have described today, likely to change as a result of the conversion from your perspective?
A. No, they won't. The pressures and challenges to balance competing needs will be the same and our contracting approach will need to be the same to meet them.

MS. EMERSON: Thank you, Mr. Ancell. No further questions at this time.

CROSS-EXAMINATION

BY MS. DeLEON:

Q. Good morning, I am Melanie DeLeon.

A. Good morning.

Q. Could you tell me who are your top five competitors in your opinion?

A. Competitors from -- in terms of contracting with physicians, is that what you are asking?

Q. If terms of Premera as a healthcare.

A. Sure. We compete with Regence, Group Health, United, CIGNA and Aetna. Eastern Washington Regence is known as Asuris.

Q. Are those in order of importance from top to bottom?

A. No. I was just trying to list them -- I was just trying to list the top.

Q. Who is currently the biggest competitor in Washington?

A. It depends on how you define biggest competitor. If you are talking about total size of the market, Regence would be. If you are talking about in terms of challenges with a particular -- making -- selling a particular account, it is often a different competitor.

You heard Ms. Donigan reference our attempt to win the Washington Mutual account, and Regence was not a competitor in that case, it was CIGNA, Aetna and United we were competing against.
Q. Does that happen often where you are competing against a nonBlues provider?
A. Yes.
Q. The surveying that we talked about was done in 2003; is that correct?
A. Yes, it was.
Q. And I am looking at the survey, P-38, the overview of the survey.
MS. EMERSON: Excuse me, I have to get him a copy.
A. I have it.
Q. Does the survey company write the questions the physicians answer?
A. They would work in collaboration with our market research department at Premera to do that.
Q. So your market research focuses in on certain questions that they want asked?
A. Along with the research company, yes.
MS. DeLEON: Could you turn the slide off, please. Thanks. It was just kind of glaring on me.
Q. For this particular survey, they took a random

sample of 4,829 physicians; is that correct?
A. Yes, I believe so.
Q. And they paid a hundred dollars to the first 500 respondents?
A. That's correct.
Q. And 584 responded?
A. That's correct.
Q. So all of the percentages that you have talked about, the 75 percent and the 69 percent, is based upon the 584 responses?
A. That's correct.
Q. Does the survey have any questions regarding the conversion to your knowledge?
A. No, it did not.
Q. Would you continue doing the survey as a for-profit company?
A. That would be our intention, yes.
Q. I believe you testified that Premera works hard at building and maintaining positive provider relations and -- throughout the state by reimbursing providers at a fair and market appropriate rate; is that correct?
A. That's correct.
MS. EMERSON: I am sorry, just for the record, could counsel please refer to the exhibit from which she is reading?

JUDGE FINKLE: I think she was referring to previous testimony. So if there is a reference to a specific exhibit, I will certainly sustain your objection. This was P-38, in general.

BY MS. DeLEON:

Q. Well, what I am looking at is his prefiled direct, but you did say market appropriate rates; is that correct?

A. Do you want me to go somewhere in that?

Q. No. I am making a statement, and then we are going to move on.

MS. EMERSON: I will object as mischaracterizing the witness's testimony.

Q. If you would like to turn to page four of your direct testimony, lines 22 and 23, and I will read them again -- or read them for you. "Premera works very hard at building and maintaining positive provider relations throughout the state by reimbursing providers at fair and market-appropriate rates, ..." that's a portion of that sentence, it goes on to the next page; is that correct?

A. That's what it says, correct.

Q. Who decides what's market appropriate?

A. We have a healthcare economics department that works to look at healthcare cost trends, looks at -- based on

whatever competitive market information we can get to see what other health plans are providing, and also takes into consideration, where available, cost information on provider costs.

Q. In your direct testimony, on page five, you reference two examples of when you meet with -- where. "...Premera has established a number of forums to elicit and address provider input." One, was the Relative Value Practice Patterns Committee; is that correct?

A. Yes.

Q. And this one convenes in Spokane?

A. Yes.

Q. And then down in the paragraph you reference the Regional Advisory Physician Panel; correct?

A. Yes, I do.

Q. And that consists of physicians in Spokane and specialists and hospital staff in the Tri-Cities and Wenatchee?

A. Wenatchee actually includes Central Washington as well. So providers around Wenatchee come into it.

Q. Is there a reason that you provided two examples of groups that meet in eastern Washington?

A. No. I can provide examples in western Washington if it is helpful.

Q. I just wondered.

A. Okay.
Q. You said in your earlier testimony today that one of the competitive advantages was that you have -- you are in every county; is that correct?
A. Yes, that's correct.
Q. And that competitive advantage would continue whether you convert or not?
A. Yes.
Q. Your direct prefile testimony on page seven, lines 10 to 15, you say that, "Between 1999 and 2003, our state-wide average rate of provider reimbursement rates increased by 20 percent, an average of 4.7 percent...;" is that correct?
A. That's correct.
Q. Do you know how that compares with your competitors that you described for me today?
A. Of course, we have to do our best to get competitive data. We don't have, as you would expect, full access to our competitors' information, but we believe it is very competitive in terms of -- if you look at their numbers, they will be comparable.
Q. Okay. You also say in your prefiled direct that Premera's contracting approach would basically stay the same or the process would stay the same?
A. Can you show me where you are referring?

Q. Page 10, under the first question, it says, "Are provider reimbursement levels or the contracting process likely to change materially as a result of the conversion," and you answer "absolutely not"; is that correct?
A. That's correct.
Q. The process means how you do the contracting, not the contract terms themselves; correct?
A. Well, what I was meaning to talk about was overall the conversions, not to have them picking the process or the terms. So I wouldn't read it that finely.
Q. Down on the page a little bit further, line 16 through 17-ish, it says, "Providers will not suddenly be more willing to accept lower reimbursement because Premera has become a for-profit entity. We will be the same company trying to compete in the same competitive landscape;" is that correct?
A. That's correct.
Q. In your opinion, what's the point of converting?
A. Because, as has been mentioned, it will provide us access to capital, and that capital will allow us to do a number of important things to better serve our members.

I think they have been reviewed, but it provides us better financial flexibility, and it will allow us to

make investments in such things as our care management programs or our systems to stay competitive in the marketplace.

MS. DeLEON: I have no further questions.

CROSS-EXAMINATION

BY MR. COOPERSMITH:

Q. Good morning, Mr. Ancell.

A. Good morning.

Q. My name is Jeff Coopersmith, and I am here on behalf of the Washington State Medical Association and the Intervenors as a group.

Mr. Ancell, in response to one of your attorney's questions this morning, you said, quote, that, "Premera's competitive advantage is that we are local," closed quote.

Is Premera prepared today to commit in writing and under oath that it will remain a local company and not sell to an out-of-state health plan?

MS. EMERSON: Objection, argumentative.

JUDGE FINKLE: Overruled.

Q. You may answer the question.

A. Right now, we are not going to make a commitment to something we don't know what the future landscape is going to look like. Actually, I am not the best person

to respond to that. I believe Mr. Barlow is the correct person, and I believe he has already responded to that.
Q. So we will take that -- your answer to that question though is no; is that correct?
A. That's not what I said.
Q. Is it no or yes then?
MS. EMERSON: Objection, asked and answered.
JUDGE FINKLE: Sustained.
Q. All right. Mr. Ancell, let's move on to the testimony that you filed for this proceeding in which you talked about network adequacy, and you stated that, quote, "Network adequacy creates a significant incentive to maintain broad and robust networks in every area of the state where a health plan has membership," closed quote. That's from your direct testimony, page four. And you have adopted that statement as part of your testimony, have you not?
A. Can you point to me again? You didn't tell me what page before you read it.
Q. Sure. Page four.
A. Uh-huh. Where at?
Q. Lines 19 and 20, "This creates a significant incentive to maintain a broad and robust networks in every area of the state where a health plan has membership," closed quote. Do you stand by that

statement?

MS. EMERSON: I am going to object to the form of the question. The witness should be given the opportunity to understand the statement in the context of all of his testimony. He is being asked to affirm one single sentence.

JUDGE FINKLE: The witness can speak for himself. But if you understand the question, go ahead and answer it. If you need more context, offer that.

THE WITNESS: Can I just read the preceding portion of the testimony so I am familiar with it -- exactly what we are talking about here?

A. Yes. I would say that's -- I agree with that statement.

Q. All right. And by that statement do you mean we shouldn't worry about patient access if Premera converts to a for-profit company, because adequacy will protect us; is that correct?

A. No. What I mean is that it creates a significant incentive to maintain a broad and robust network in every area of the state.

Q. Is there a concern that -- well, is there a concern then if Premera converts to a for-profit company that there might not be patient access?

A. No.

Q. Okay. How much time --
JUDGE FINKLE: I am sorry, just a second.
MS. EMERSON: I would like to just object to counsel's last question as vague.
JUDGE FINKLE: Overruled.
Q. How much time, Mr. Ancell, have you spent analyzing network adequacy regulations?
A. I personally did not spend a lot of time analyzing --
Q. I understand. I asked -- this is your testimony, and I asked how much time you spent analyzing network adequacy regulations, and what is your answer?
A. I have not personally spent a significant amount of time doing that.
Q. Okay. And whatever time you did spend analyzing these regulations, do you draw on your legal training and experience?
A. I do not have any legal training and experience.
Q. You are not a lawyer; correct?
A. No, I am not.
Q. Okay. And are you familiar then with which segments of the market the network adequacy regulations apply?
A. No, I am not.
Q. So you wouldn't know what percentage of the market is governed by network adequacy regulations; is that

correct?
A. I am not sure I understand the question.
Q. Do you know what percentage of the health insurance market in this state is governed by network adequacy regulations?
MS. EMERSON: I am going to object as vague.
JUDGE FINKLE: Overruled.
A. I don't know what you mean by percentage of the market.
Q. Well, is every -- is every person who has health insurance in the state of Washington protected by network adequacy regulations?
A. I believe the answer is then no, I am not aware of the percentage in the market.
Q. Do you know what would constitute a violation of network adequacy regulations?
A. I don't know all the details, other than under the understanding we have to file a plan of network adequacy, and the insurance commissioner holds us -- and the staff holds us accountable to it.
I also know that the staff is very concerned with adequacy and frequently will have conversations with us if they believe a provider is going to leave our network because of adequacy concerns.
So without being specific about all of the

regulations, from a practical basis I am very familiar with the impact to regulations the insurance commissioner oversight has on our network adequacy, because I do deal with that on a regular basis.

Q. Are there federal standards, Mr. Ancell, for network adequacy?

A. Not that I am aware of.

MS. EMERSON: Objection, calls for a legal conclusion.

JUDGE FINKLE: Well, not a legal conclusion, to the extent that you know based on your responsibilities.

Q. Correct. And are there state standards for network adequacy to the best of your knowledge?

A. Yes.

Q. There are?

A. They require that we comply with the plan of adequacy that we filed and have been approved by the commission.

Q. And that's the company's own standards; isn't that correct?

A. We set the standards and then they are approved.

Q. And can you tell us something about the enforcement history of the network adequacy regulations? For example, what's the largest fine ever imposed for a

violation?

MS. EMERSON: Object, foundation.

JUDGE FINKLE: To your knowledge, go ahead.

A. I cannot answer that question.

Q. Okay. Would it be surprising if the answer was zero dollars imposed?

A. As I said before, I don't have the answer to the question.

Q. And you state in stage three of your direct testimony, the lines 23, 24, you say that, "... because we have membership throughout the state we want to maintain a network in every county in the state," closed quote.

Is the reverse also true that if Premera withdrew from any part of the state that it wouldn't need a provider network there?

A. Could you point to me? I didn't see --

Q. Lines 23 to 24?

A. On page three of the prefiled direct?

Q. Correct.

A. Okay. Actually, no, I don't think that would be true. Because, as a member of the Blue Cross/Blue Shield Association, we provide access for all of the Blues nationally. And so whether we have membership there or not, it would be important to maintain the

network.

We also have a Blue license, in most counties of the state, and to abandon that county we would run the risk to lose the licensure in that County, which as we discussed previously, we view as a valuable asset of the company.

Q. You also boasted in your prefile direct testimony that under one percent of your providers left Premera's network during the last two years; is that correct?

A. Can you direct me to that, please?

Q. Page four, lines 2 to 3.

A. Yes, that's correct.

Q. And could that just as easily be because the physicians have no place to go and that they have to stay with Premera?

A. I believe there is a competitive market the physicians have in terms of who they can contract with in the state.

Q. Turning to the question of physician satisfaction, the questions I am about to ask you, Mr. Ancell, are based on what Premera had provided to the Intervenors up to 10:30 this morning. It is Premera -- is it Premera 36 or 38?

MS. EMERSON: I believe it is 38.

MR. COOPERSMITH: Thank you, counsel.

Q. And you cite this survey as proof of physician satisfaction with Premera; is that correct?
A. I cite it as an indicator that we use to track physician satisfaction.
Q. Well, in fact, you defend Premera against criticism from the WSMA, and from Dr. Collins in particular, with the survey results; is that correct?
A. Yes, it is.
Q. In your responsive testimony you called it quote "objective evidence," closed quote; is that correct?
A. You would have to point me to that.
Q. Page two, the bottom of the page, line 23.
A. That's what it says.
Q. Okay. And you stand by that statement, too?
A. Yes, I do.
Q. Okay. And the Premera 38 is not the complete survey, is it?
A. No, it is a summary of the results.
Q. Well, it is not even a complete summary of the results, is it? It is just entitled a presentation to the Premera quality committee; is that correct?
A. I believe it is a summary of the results.
Q. And so would you dispute that it is just a selective -- results from selective questions for purposes of presenting it to this quality committee?

A. No. I believe it was a summary that we thought would best convey the results of the survey to the quality committee.
Q. Do you believe that -- well, does it contain a full methodology, Exhibit 38?
A. Which one? Which page are you talking about?
Q. I am asking whether Premera's -- wouldn't characterize this as a summary as the methodology set forth?
A. It contains a summary of the methodology, yes.
Q. Does it have a list of the questions and responses?
A. No, it does not.
Q. Does the new exhibit introduced today have the complete list of questions and responses? I believe it is Premera 218.
A. Yes, it does.
Q. It has every question and every response?
A. Well, it has every question and then the summary of each response.
Q. And the sample size is apparently 4,829 physicians, spread over three states; is that correct?
A. No, that's not correct.
Q. What is the sample size?
A. 584 physicians.
Q. The random sample then was 4,829 physicians over

three states; is that correct?
A. That's correct.
Q. And there are over 10,000 physicians in the Premera network in Washington alone; is that correct?
A. That's correct.
Q. And according to this document, it says that 355 of the completed surveys came from Washington; is that correct?
A. That's correct.
Q. Yet, when you list overall satisfaction in the document, there is only 347 listed; is that correct?
A. Where are you -- can you refer me to where you are looking at?
Q. Sure. If you go to overall satisfaction on page four, and you add the western and eastern Washington figures together, you come up with 347, correct, not the 355 completed surveys that you indicated before?
A. That's correct.
Q. And likewise, on overall service, there are only 339 included in that, is that correct, even though there are supposedly 355 that are completed?
A. That's correct.
Q. And, of course, this is an on-line survey; is that correct?
A. They had the option of taking it either on-line or

by phone.
Q. And do you happen to know how many of the Washington respondents took it on-line?
A. No, I don't.
Q. And on the on-line respondents, you don't even know if those responses came from physicians, do you?
A. Yes, we do.
Q. How is that?
A. In the information -- one of the questions had to do with whether they were physicians, office staff or another type of practitioner, and in the exhibit submitted today it includes a summary of that information.
Q. Right. But someone could have put -- a receptionist, a file clerk, someone in the physician's front office could have filled it out; is that correct?
A. If they did, it was a very low percentage. The majority of those who responded were physicians.
Q. The question is you have no way of verifying whether if a person said she was a physician, was in fact a physician; is that correct?
A. I guess that would be correct, yes.
Q. Okay. And you also tested for satisfaction from Premera and LifeWise of Oregon; is that correct?
A. That's correct.

Q. And is it possible that some of the surveys in Vancouver and southwest Washington could have been for the Oregon plan then?
A. I doubt that, but it is possible.
Q. It is possible? Thank you. And everyone who responded knew that the survey came from Premera; is that correct?
A. They were informed of that, yes.
Q. Yeah. And you also said in your testimony today that they were told by the survey firm that that information wouldn't be relayed to Premera; is that correct?
A. That's correct.
Q. But they had to -- the physicians or whomever responded, they didn't have any particular reason to trust this survey company; right? There was no prior relationship with the survey company; is that correct?
A. They didn't have a reason to distrust the company.
Q. Or trust them either way; correct?
A. I suppose you could say that.
Q. Okay. And on page three of the survey document you have here, Premera 38, you state -- try to enunciate -- you indicate that, quote, "The highest impact on satisfaction is the ability to resolve questions regarding payment and promptness of claims

reimbursement;" is that correct?
A. That's correct.
Q. But there is no indication there of how Premera rated on either one of those scores; is that correct?
A. Actually, what that is doing -- actually, there is an indication how Premera scored on that. Because what that's saying is that when they looked at the survey they were able to tell what are the things that are driving overall satisfaction. And things that are most significantly driving overall satisfaction, the thing that physicians most commonly referenced when asked, "What are the top indicators of overall satisfaction," were those two factors.
That information, taken with the fact that we scored very high on overall satisfaction, is an indicator of how we performed in those --
Q. That information is presumably then in your Exhibit 218; is that correct?
A. That's correct.
Q. All right. And it also says that, quote, "Negative ratings are due to issues related to low reimbursement levels," closed quote. So that contributes to the negative view of Premera; is that correct?
A. There were approximately four percent of the physicians that did not rate Premera as good as, better,

or much better than other health plans. Of those four percent, when asked, "What contributed to the negative rating," that was one of the contributors. So it was a very small portion of the responders that indicated that.

Q. Well, again, the WSMA reserves the right to recall this witness after reviewing the data provided today.

Let's move on now to reimbursement. And you have already testified that it is your belief that Premera pays physicians at a market appropriate rate; is that correct?

A. That's correct.

Q. And who sets that market appropriate rate?

A. I actually answered that question earlier. I don't know if you want to go back to that question or --

Q. Premera sets that rate, was that your testimony? That you look at -- your healthcare department looks at healthcare costs and what you know of what competitors pay and sets a rate; is that correct?

MS. EMERSON: I am just going to object as mischaracterizing his testimony. There is testimony about rates relating to standard fee schedules, as well as to customer contracts.

JUDGE FINKLE: I take this as a new question, so go ahead and repeat the question if you

would.

MR. COOPERSMITH: If I can.

Q. Does -- how does -- who sets these market-appropriate rates, Mr. Ancell?

A. Okay. We have a healthcare economics department, and that department will look at a number of factors -- as I believe I mentioned before -- healthcare cost trends overall.

They will also look at any information we have on the impacts of provider fees and individual provider offices. And then, to the extent we have available to us, we will consider data from other health plans and what they are doing with their fee schedule, and from that attempt to develop a competitive rate that balances the needs of physician reimbursement with the needs of our members for competitive market premiums.

Q. But if a health insurer has a dominant role in the market, then it would be able to set the rate for reimbursement -- effectively only competing against itself.

MS. EMERSON: Object to the term "dominant" as vague and ambiguous.

JUDGE FINKLE: You may answer it if you understand the question.

A. I guess I can't really speak to that because I am

not familiar with contract in that environment. I don't believe that's the environment we contract in.

Q. All right. Mr. Ancell, you are a Harvard MBA, let me ask you the question this way then.

Do you agree that a plan with less than one percent of the market share has less influence on a physician reimbursement than a plan that has 70 percent of the market share?

A. It depends on what you mean by influence. If you mean less ability to get a competitive rate, no, I don't agree with that. Actually, a lot of top physicians want broad competition in the market, so they are in fact willing to give very competitive contract rates to new entrants to the market because they want to promote a robust environment out there. So you can, I believe, get very competitive contract rates for new entrants.

Q. I just want to make sure I am understanding your testimony then. Are you saying then that a health insurer with one percent of the market rate has just as much ability to set compensation for physicians as a health insurer that has 70 percent of the market?

MS. EMERSON: I am going to object on two grounds. One, it has been asked and answered, but there has been no foundation laid that this witness is qualified to testify on matters of economics.

JUDGE FINKLE: I am going to allow his opinions to the extent he is able to answer the question. He can certainly say "I don't feel competent to answer a particular question," if that's your view. Go ahead.

A. I am not sure what the question was. Can you ask it again?

Q. Sure. I just want some clarification about your testimony. Is it your belief that a health insurer that had one percent of the market has the exact same ability to set compensation for physicians as a health insurer with 70 percent of the market?

A. I guess I can't speak to -- if you are just talking about the economics of it, I can't address that.

Q. All right. Mr. Ancell, you also state that physician reimbursement by Premera has gone up an average of 4.7 percent between 1999 and 2003; is that correct?

A. That's correct.

Q. And that you expect that Premera will increase the average rate by 3.5 percent this year; is that correct?

A. We in fact implemented a fee schedule increase September 1st, 2003, which would be in effect starting then.

Q. That's correct.

A. Increase it on average at that rate.
Q. Thank you. I am sorry for that. Thank you for that clarification. It is 3.5 percent, that's what I am getting at.
A. That's the overall average increase, yes.
Q. Even if we accept those numbers, that average includes both the standard contracts and the special deals; is that correct?
A. No, that's not correct. That's the standard contract.
Q. Okay. And then during the period between 1999 and 2003, are you aware of what the general inflation rate was?
A. You are talking about for the economy?
Q. Yes.
A. I can't say specifically what it was, no.
Q. Okay. And you mentioned that healthcare inflation itself is in the double digits; is that correct?
A. What I said was healthcare premium trends have been going up about 15 percent a year.
Q. What's your understanding of healthcare inflation between 1999 and 2003?
A. I don't know what you mean by inflation.
Q. The costs of goods and services, healthcare goods and services, between 1999 and 2003?

A. Well, I know there is a number of -- and I am not an expert in this area -- but there is a number of different indicators. There is a hospital index and there is a physician medical price index, and I actually believe the hospital one has been in the neighborhood of four to four and a half percent, and the physician one has been in the neighborhood of three percent.

Q. Okay. And can you turn to -- can we put back on the screen exhibit 90, Premera Exhibit 90? You had this particular depiction up of market dynamics during your direct testimony today; correct?

A. That's correct.

Q. And the suggestion here, and also in your prefiled testimony, is that there is some kind of a tension between consumer and provider demands; is that correct?

A. That's correct.

Q. And specifically there is a tension between the consumer desire for lower premiums, and the provider's desire for greater reimbursement; is that correct?

A. That's correct.

Q. And in response to questions from your lawyer, you said that one of the reasons -- one of the factors that goes into deciding reimbursement is what the impact will be on premiums; is that correct?

A. That's correct.

Q. All right. And can you tell us then at the same time -- the same time period where a physician reimbursement by Premera went up an average of 4.7 percent, what were the rate increases Premera received in the individual markets, between 1999 and 2002?
A. I can't answer that.
Q. Would the figure 90 percent surprise you?
A. I can't answer that.
Q. Okay. And during that same time period, what were the premiums that Premera -- premium increases that Premera received and charged during that time?
A. I can't answer that.
Q. And would over 50 percent surprise you?
A. I can't answer that.
Q. Okay. And speaking of reimbursement, Mr. Ancell, can you tell us how much you get compensated by Premera?
MS. EMERSON: I am going to object that it calls for personal information.
MR. COOPERSMITH: It goes to motive, Your Honor.
JUDGE FINKLE: Overruled.
A. In the neighborhood of $700,000 a year.
Q. All right. And how much -- nice neighborhood. How much do you stand to gain by -- how much do you stand to gain financially by the conversion, Mr. Ancell?

A. To my knowledge, there is -- I will not gain anything from the conversion. I think the prior testimony was clear that if there would be any benefit, it would be longer term through improvement in the company's performance over time.
Q. Is it your testimony that if Premera converts, you will not -- at that time or subsequently -- have any financial gain as a result of that, other than improved performance?
MS. EMERSON: Objection, asked and answered.
JUDGE FINKLE: Overruled.
A. I have not looked at it in detail. That has not been the focus of the company in terms of conversion.
Q. I didn't ask what the focus of the company was, Mr. Ancell. I asked you a very specific question. What is it that you stand to gain financially by Premera's conversion to a for-profit company, either at the time of the conversion or some subsequent time?
A. And I believe I answered it, and I said I have not looked at that.
Q. So you just have no idea then, that's your answer?
A. Yes.
Q. Okay. And then what do you stand to gain financially if a converted Premera is subsequently sold to another company?

A. I have not looked at that.
MS. EMERSON: Objection.
Q. Okay. And, Mr. Ancell, you are now -- give us your title again, I am sorry.
A. Executive vice-president of healthcare services and strategic development.
Q. Were you the only applicant for your job?
A. I cannot answer who Mr. Barlow considered for the position.
Q. Okay. And you have been on the senior management team since 1997; is that correct?
A. Since 1996 is when I joined.
Q. 1996, pardon me. Is it your impression that Premera has had a hard time filling jobs in senior management because of inadequate pay and benefits?
MS. EMERSON: I am going to object, lack of foundation.
JUDGE FINKLE: Impression gets a little vague.
Q. Okay. Is it your experience that Premera has had a hard time filling jobs in senior management because of inadequate pay and benefits?
A. My experience is that it is a very competitive market, and attracting good talent is difficult to do, And at times we have had trouble filling positions. I

believe, over time, we have been able to put together a very strong team.
Q. Can you be specific about what positions you had a hard time filling that went vacant for a long time because of inadequate pay or benefits?
A. Sure. Our head of network development had a difficult time filling that at one point.
Q. Any other position in the past seven years?
MS. EMERSON: I will object, lack of foundation.
JUDGE FINKLE: Overruled. Go ahead.
A. Well, let me think for a minute. I am not thinking of other ones off the top of my head, no. If I took more time I may be able to think of one.
Q. Thank you, Mr. Ancell. Let's move now to contract negotiations. You have disputed the notion that Premera engages in a take-it-or-leave-it attitude; is that correct?
A. I disagree with that approach or that notion, yes.
Q. Okay. And in your prefiled testimony, you gave examples of where providers of healthcare would have leverage with the company; is that correct?
A. You would have to point.
Q. Do you recall saying that there were four examples, one of which was physicians who are in isolated areas?

A. Could you point me to the section you are referring to?
Q. Sure. It is in your prefiled direct, page eight and nine. The first example you give is, "Providers in less populated areas;" is that correct?
A. Yes, that's correct.
Q. Okay. And by definition there are few providers in less populated areas; is that correct?
A. That seems to make sense.
Q. And the second example you give is, "Highly specialized practices," on page nine. Again, by definition, there are few physicians in highly-specialized practices; is that correct?
A. Not necessarily, no. What the trend has been is for physicians in specialties to merge together in particular specialty groups. So there may be a sufficient number of the physicians, but they have just formed a group practice and they negotiate as a group practice.
Q. But the premise is that the more highly specialized your area of medicine, the greater your leverage would be; correct?
A. That's the statement there, yes.
Q. Correct. Okay. And, therefore, the opposite must be true, that the less specialized your practice, the

less leverage you have. So if you are involved in primary care, for example, you would have less leverage; is that correct?
A. There are more primary care physicians available in the market, and so there is less need for us to pay higher rates of reimbursement for those providers above our standard fee schedule.
Q. So you have less leverage with Premera, is that correct, if you are a physician engaged in primary care?
A. If that's your interpretation.
Q. Okay. And the next example you give are large multi-specialty clinics, and is it fair to say there are only a handful of those in the state?
A. Actually, I think there is quite a number of them. I can think of -- I believe there is in the range of 20. So if you believe that's a handful, then it is a handful, but I think that's the range.
Q. Okay. And there are six million people in the State of Washington or thereabouts, does that sound about right?
A. Yes, that sounds roughly right.
Q. Okay. However many large multi-specialty clinics there are in the state, most of them are in urban areas of the state; is that correct?
A. It depends on how you define urban. Wenatchee

Valley Clinic, I don't know whether you consider Wenatchee area urban, but they have a number of satellite offices in that area.

And I would also point out that I believe about 30 percent of all physicians in the state practice in multi-specialty clinics.

Q. Let's turn to that issue actually, that's the fourth issue you identified, provider consolidation. And you -- now, isn't that provider consolidation in fact driven by the fact that there is consolidation among the health insurers, that physicians no longer are able to negotiate with Premera, and so they merge into bigger practices; is that correct?

MS. EMERSON: Objection, compound.

JUDGE FINKLE: Could you ask the question again.

MR. COOPERSMITH: Sure.

Q. Is provider consolidation in fact a result of health insurance consolidation?

A. I don't know that for a fact. I think there is many reasons it can go into a group deciding to consolidate.

Q. You give two examples there, the orthopedic example and the GI -- gastroenterology -- example. Were you aware that the frustration with negotiating with Premera was part of the reason behind that -- Premera and

another payer in the market, and that they wanted to gain more leverage? Are you aware of that fact?
A. That has not been communicated to me by the group, no.
Q. Okay. And you also mentioned in your testimony today about the dimensions platform; correct?
A. Yes, I did.
Q. But you didn't mention the fact that the dimensions platform places physicians in tiered groups, but that is the case; is that correct?
A. The system itself doesn't do it. We do offer a few different networks with dimension, that's correct, in terms of the product design.
Q. Okay. And that the -- are you aware that the physicians fear that by placing them in different tiers that will enhance Premera's leverage with physicians?
A. I can't say that -- no, I can't say that.
Q. Okay. And then also with regard to leverage, you identify in your testimony that 20 percent -- rather, 30 percent of the market in Spokane has non-standard contracts. Do you recall that?
A. Can you point that to me?
Q. Sure. In your responsive testimony, page three, lines -- I can't really tell, 12 to 16, quote, "Across the state, some 33.2 percent of our claims for physician

services are paid at negotiated rates in excess of our standard fee schedule. In Dr. Collins's hometown of Spokane, the figure is 30.7 percent, and in Washington the figure is 43.9 percent," closed quote; is that correct?

A. That's correct.

Q. And you stand by that quote?

A. Yes, I do.

Q. So that means that almost 70 percent of the physicians in Spokane have the standard fee schedule; correct?

A. That would seem to be the corollary, yes.

Q. Right. And by standard fee schedule they get -- if you saw my grades in math, you wouldn't assume I would know that.

So for those 70 percent, the physicians assigned those contracts are offered that rate and no other rate; is that correct?

A. We offer them a standard contract. If the physician desires to have a non-standard contract, they can approach us and we will have a conversation about whether or not that's appropriate, looking at the factors I discussed earlier to determine whether it is the right thing to do for our members.

Q. But the fact is that almost 70 percent of physicians

in Spokane are -- have signed that standard contract; is that correct?
A. That's correct.
Q. All right. And is it your testimony that when they had that conversation expressing their concern, that then Premera listens to that concern and then changes its mind sometimes?
A. Yes.
Q. But apparently not a lot of the time?
A. About the same amount of time as we do in western Washington.
Q. Right. And for the state, as a whole, it is about two-thirds of all physicians in the state who have just the standard contract; is that correct?
A. Let's see. Yes, that looks right.
Q. And is it also fair to assume that when you say a negotiated contract, by that you mean that the -- any negotiated contract is presumably higher than your standard fee schedule; is that correct?
A. Not in every case, interestingly enough.
Q. Some physicians negotiate downward from the --
A. Actually, believe it or not, yes. We do have situations where, for particular reasons, for example, they want to stay on an older version of RBRVS of our standard contract, and we are willing to accommodate for

that. And we are surprised when it happens, but it does happen.

Q. But that's a rare occasion?

A. That's a rare occasion.

Q. Okay. So I think it is safe to say then that if you have a negotiated contract, you are almost always getting a better rate than a standard contract?

A. Yes, that's true.

Q. And since you are involved in provider relations and provider negotiations, are ultimately responsible for them; correct?

A. Uh-huh.

Q. Is it your experience with physicians that they would rather have a standard rate or that they would rather have a negotiated rate?

A. I would say that depends on the physician. A lot of physicians don't -- to negotiate a non-standard contract takes time and effort and energy on the physician's part, as well as on Premera's part. And many physicians don't want to invest that time and energy, and we believe are quite happy with the standard fee schedule we offer.

That's why we offer a competitive standard fee schedule, so when we offer that fee schedule they don't have to go through the difficulty of negotiating a

non-standard contract.
Q. Is it your belief, Mr. Ancell, that the reason why some physicians don't choose to negotiate with Premera is that they are happy with the rate offered by Premera, or that they don't want to engage in that long and difficult process that Premera puts them through?
MS. EMERSON: Object to the characterization.
JUDGE FINKLE: Overruled.
A. I believe that the vast majority of physicians are happy with the rate we offer, as evidenced by the fact we roll out a fee schedule we don't get a lot of complaints from physicians. In fact, sometimes we get calls from physicians appreciative of the rates.
I also don't believe we have a long and difficult process for contracting. I think we try and make it as easy as possible for the physician when we can do that.
Q. I just want to make sure we understand here. Do you believe that the fact that physicians don't come forward and ask for a better contract rate is because they are satisfied with the rate or because they feel they can't do any better, even if they did invest the time and resources to try to get a better deal?
A. I can't speak for what any individual physician believes or doesn't believe. My belief is, on the

whole, physicians are satisfied with the contract rate they pay.

If you ask me would every physician prefer a higher rate, the answer is absolutely they would prefer a higher rate.

If you ask me does that mean they are unsatisfied with Premera's rate? I don't think that's the same thing.

Q. Finally, turning to the next slide, if you will, on that exhibit -- isn't that part of the same exhibit? You were shown Exhibit 90, which is up there.

MS. EMERSON: This is the only slide that we have identified with this witness.

Q. Do you have Premera Exhibit 90 in front of you then?

A. Yes, I do.

Q. Could you turn to the next page where it says, "Where does your healthcare premium dollar go?" It can't be made available on the screen, do you have it in front of you?

A. Uh-huh.

Q. You have a dollar bill divided up there, don't you?

A. Yes, I do.

Q. Okay. And the dollar bill says that 84 cents of it goes to healthcare payments; correct?

A. That's correct.

Q. And then four cents goes to premium taxes and commissions; correct?
A. Yes.
Q. And 11 cents goes to operating costs; is that correct?
A. That's correct.
Q. And finally one cent goes to operating profit?
A. That's correct.
Q. Is it your understanding from Mr. Barlow that the purpose of the conversion is in part to double or triple operating margins?
A. No, it is not.
Q. You dispute that that is part of the intention of the conversion?
A. I absolutely do.
Q. Do you believe that the intention of Premera by converting is to increase operating margins at all?
A. No. I believe the testimony that's been given on that is that Premera needs to increase its operating margins, whether we are non-profit or for-profit, to remain competitive as a healthcare company. That is not the purpose for converting.
Q. Let me just ask you again, upon your Harvard MBA here, and looking at this diagram. Now the four cents, most of that is in premium taxes; correct? You do a

little something about the appropriateness, I assume, but most of that is premium taxes; correct?

MS. EMERSON: I will object on foundation grounds and compound.

MR. COOPERSMITH: If you know.

JUDGE FINKLE: Overruled. If he knows.

A. I believe premium tax is about half of that.

Q. And 11 cents of that is operating costs. The question is, if you are going to increase your operating margins, can you do it just out of the 11 cents of operating costs? Or do you have to look at the 84 cents that goes to payment for medical services?

A. This exhibit is not Premera-specific data. This is a general industry exhibit. Premera's operating costs are actually slightly higher than 11 cents.

And so we have the opportunity, through greater efficiencies, to reduce our operating costs. Our margin, I believe, has been indicated of about 1.7 percent. We would like to increase that to about three percent -- would be an increase about 1.2 percent. And we believe the majority of that or all of it we will be able to get out of greater administrative efficiencies.

Q. Did you hear Mr. Milo state earlier that 84 percent of Premera's healthcare costs -- 84 percent of Premera's costs go to healthcare payments?

A. Yes, I did.
Q. Do you agree with that assessment?
A. That's my recollection of roughly what our numbers are, yes.
Q. So the question is whether you believed it is possible to achieve greater operating margins solely out of operating efficiencies and without reducing payments for medical services at all?
A. That's our intention, yes.
Q. That's your intention?
A. And I believe that that's possible.
Q. Okay. And so why if it is possible to achieve all these operating efficiencies, why don't you just do them now instead of converting?
A. We are working very hard to do them now. I believe what we have presented is that we need additional capital to continue to make investments, and that's the purpose for converting, is to obtain that additional capital.

MR. COOPERSMITH: No further questions at this time.

JUDGE FINKLE: I am inclined to finish the witness if it can be done relatively quickly, but if you have extensive redirect we can break.

MS. EMERSON: It is not extensive.

REDIRECT EXAMINATION

BY MS. EMERSON:

Q. Mr. Ancell, you were asked by Mr. Coopersmith about the physician satisfaction survey.

A. Yes.

Q. And that as -- and I believe you testified that that was one indicator of your understanding and the company's understanding that physicians -- physician satisfaction has improved.

Can you tell us, are the survey results consistent with other feedback that the company has received about physician satisfaction?

A. Yes, they are. We do a number of things to assess satisfaction. We -- as I mentioned before, for our care facilitation programs, we do satisfaction surveys of physicians, as well as our members.

We also have a prescriber satisfaction survey that is done for anyone that writes prescriptions, and we get feedback on the prescriber satisfaction survey. We also have our advisory groups that gives us feedback on how we are doing.

So we have a number of ways that we try to assess and gauge feedback. Then we do get the opportunities for improvement, and we take every advantage we can to

give opportunities, try to get better at how we work with physicians.

Q. Can you give us a sense of the nature of the feedback that the company has received in the last couple of years?

A. It has been very positive in the last couple of years. I will say, in 2000 when we started our efforts, it was not very positive. So we have seen quite a bit of turnaround in the last several years, which I think is a direct result of the efforts we have made to improve relationships.

Q. You were also asked by Mr. Coopersmith about the impact of healthcare costs on premiums, and you were asked specifically about the impact of the increases from the standard fee schedule, the 4.7 percent, for example.

Other than the actual direct physician healthcare costs, is there another component of healthcare costs that go into premium calculations to your understanding?

A. Yes. There is a number of other coupons that go into it. In particular, utilization trends, which are, in addition to any rate increase, the utilization -- the number of times people go seek service is continuing to go up significantly.

Pharmacy cost trends and pharmacy trends, both in

cost and in terms of utilization pharmacy, has been increasing. And then hospital cost trends. So there is a number of factors that go into the premium.

Q. Then finally, you were asked by Mr. Coopersmith about efforts by Premera to attract new members of management. Do you recall that testimony?

A. Yes, I do.

Q. Mr. Ancell, are you responsible for hiring and recruitment within Premera?

A. No, I am not.

MS. EMERSON: Thank you. No further questions.

MS. DeLEON: No questions.

RECROSS-EXAMINATION

BY MR. COOPERSMITH:

Q. So then, Mr. Ancell, it is true then that there are a number of different factors that go into premium rates besides reimbursement for medical services; is that correct?

A. That's correct.

MR. COOPERSMITH: No further questions.

EXAMINATION

BY COMMISSIONER KREIDLER:

Q. Mr. Ancell, let me ask just a couple of questions here. One of them is that the physicians' satisfaction surveys that have been discussed rather extensively, is it fair to say that it is not portrayed to be -- so to speak -- a scientifically-approved survey, comparable to what might be understood as kind of a polling type of information that's done meeting certain statistical standards of random nature and so forth?

A. I actually believe it was intended to meet those. And I am not an expert in that area, but the company we hired, Morpace, this is what they do. And I believe that's the reason we gave them the entire file of all of our physicians, so they could select a random sample.

My understanding is the sample size -- the reason they set the sample size at 500, was that that was the threshold that was needed to be statistically valid.

Q. The reason I ask that is because it appears when you mail out to 5,000 physicians or something like that, and you rely then on the ones that respond -- the first 500 get a hundred dollars for responding to the survey, that that doesn't necessarily represent the kind of random nature of what I am used to for a survey.

A. Okay.

Q. And I remember, when I was a legislator, we mail out questionnaires, we would get a fairly small number that

would respond and drawing generalizations from that was always somewhat hazardous, but you did point out that this is just one tool, among several.

A. That's correct.

Q. I am wondering when you mentioned the issue of competitive rates, that if there is a new -- so to speak, a new entrant into the marketplace for physicians, that they often give, I believe, you used words somewhat that they can often give very competitive rates, in order to make sure that entrant is in the market.

To what extent does that influence what they will be in the future compensated if they are in fact giving a better rate perhaps to a new entrant, as opposed to what they are giving to Premera or to any other large carrier that is in the marketplace currently?

A. I am not sure if every case they give a better rate, they may give as competitive. I believe in some cases they do give better rates to do that. And I think their intention is -- their belief is by maintaining robust competition in terms of health plans, that allows them to have a choice of who they contract with over time, which will be, in the long run, positive for them. I believe that's the reason they would be willing to do that.

Q. Thank you. One of the issues -- just kind of came up at the end -- relative to kind of utilization, and you were mentioning that utilization trends, if I am not mistaken, are going up, meaning that subscribers may access a physician more frequently for particular healthcare needs; is that correct?

A. That's correct.

Q. What is Premera currently doing to manage utilization trends?

A. Dr. Chauhan is going to talk extensively about that, but the way we do it is through our care facilitation programs. So we have case management nurses, which are the nurses I have described, who will work with individuals to get them into the right type of care. And at the same time it can be better quality but it can also be cost savings.

We find for every dollar we invest there we get about a five-to-one return. We also have disease management programs that take care of members that have, for example, diabetes, specific disease types. We find those programs return about two dollars for every dollar we invest.

We have pharmacy management programs, and those pharmacy programs help make sure the members are getting the right medication, but also cost-effective

medication.

But we have a number of different programs like that that we invest in, and we would like to increase our investment in those programs because they are a way that we can help control appropriately utilization increases, not through denial of care, but through getting members the right care.

Q. Thank you. That kind of raises the question here relative to care programs and other improvements in provider relations.

A. Yes.

Q. I believe you said that one of the -- and we have heard it from others too -- that's one of the reasons to be able to raise capital --

A. Yes --

Q. -- and conversion offers that tool. Can you give any examples of where -- provider improvements and manage -- care management programs that would be implemented if there was access to the capital markets?

A. Sure. I can't -- we haven't made specific decisions on which programs, but I can give you specific examples of the types of programs we would be able to implement if we had additional capital.

One of the things Ms. Donigan testified about was when we tried to win the Washington Mutual account, we

did not stack up in terms of the computer systems that support our care management nurses. The dimension systems in our core claims and customer service system, it has not provided the infrastructure that we would like our nurses to have on their desktop available to better manage the care. So we would, with additional capital, be able to make decisions to make investments like that.

We also, in terms of the number of care management nurses we have, right now we manage .2 percent of all of the cases. We ideally would manage upwards of three percent of all the cases, and in order to do that we would have to hire additional staff. And that requires investment in facilities and a new computer system, additional computer terminals for the nurses, in order to hire and support that staff. And so we are limited in terms of our ability to do that.

And we attempt now to add -- this year we added six new nurses, but in order to get up to three percent, we would be talking about 50 to 75, maybe even more, nurses. So it is a dramatic difference.

Another example would be disease management programs. Right now, we use vendors for our disease management programs because they are able to provide the service and it is charged as a medical expense. If we

had the capital to invest in infrastructure, we could put some of those programs in-house.

And our experience has been doing it in-house with our own nurses we perform better. We have recently brought our oncology program in-house, and the vendor was promising a two-to-one return.

What we found is, in-house, with our nurses, we believe we will get a five-to-one return on the investment, but we are limited in terms of the capital to make the infrastructure investment to bring those programs in-house.

A last example I will give you around pharmacy is around E-prescribing. WellPoint has just announced an initiative with Microsoft, where they are investing in infrastructures to allow physicians in the California market to do E-prescribing. And I don't know that we are at the point where we would say we want to do that yet, but it certainly would be something that we would be -- at least have the option to consider investing in which we really don't right now.

COMMISSIONER KREIDLER: Thank you, very much.

MS. EMERSON: No further questions.

MR. COOPERSMITH: Just briefly, Your Honor.

EXAMINATION

BY MR. COOPERSMITH:

Q. The Commissioner just asked you, Mr. Ancell, about contract negotiations and Premera's approach to it. Isn't it true that there is a policy on Premera's part to reduce the number of non-standard, the number of negotiable physician provider contracts out there?

A. I would not say that's a policy, no.

Q. How would you characterize that?

A. I think that it is better for the market as a whole because that's an indication to me that we are paying our fee schedule appropriately, and it is less administratively burdensome. So I think it is a positive thing.

So in terms of good administrative simplification, we look to streamline that process by having more standard contracts, but it is certainly not a policy of ours.

Q. But Premera is devoting efforts to try to reduce the number of non-standard provider contracts in its network; is that correct?

A. No, it is not correct.

Q. It is not?

A. No.

Q. It is desirable, but there is no particular effort

on Premera's part to do that?
A. No. We do not have an initiative or program or effort to design or reduce the amount of non-standard contracting.
Q. Have you instructed your employees in the provider contracting divisions to negotiate only standard contracts wherever possible?
A. No. I don't think we have given that specific instruction, no.
Q. Have you given the general instruction toward that end?
A. No. As I said, it is desirable and they understand it is desirable to have standard contracts, but I do not believe they have been given an instruction that's all they should be doing. In fact, that's not all they do.
Q. All right. And in response to the Commissioner's questions, you mentioned the WAMU contract. And is it your testimony that Premera lost the WAMU contract because its care management tools weren't sophisticated enough?
A. Ms. Donigan's testimony, I think, generally indicated that was one of the factors --
Q. One of the factors?
A. -- that she mentioned. She is the one that spoke with the broker in terms of what exactly all the factors

were.
Q. Okay. But that's not your testimony, that that was the factor behind Premera's losing the Washington Mutual contract; is that right?
A. What I said was I referred to her testimony and indicated --
Q. I am just asking for your belief now, Mr. Ancell.
A. My belief is that's one of the factors, yes.
Q. Okay. But not the factor, that was the question.
A. I can't say it was the only factor, no.
Q. Okay. And apparently Microsoft didn't hear about care management tools being inadequate by Premera when Premera took the contract from Microsoft employers; is that right?
A. I think they think we do a good job in care management.
Q. Okay. And the Commissioner asked you for some specific examples of what you would get with conversion that you can't get now. Could you be -- I am not sure that at least I heard the answer, were you saying that you can't hire more nurses because you don't have adequate capital for that?
A. Yes. It takes capital to invest in infrastructure, facilities and computer equipment and other things, to increase our care facilitation program.

Q. Mr. Ancell, in response to the Commissioner's question you gave a specific example about 40, 50 whatever nurses. Do you believe that Premera couldn't hire those nurses in its current non-profit status?
A. We would be able to hire them more slowly. As I gave my example, we have added six more staff this year, and we will continue to, as we are able to build that department. Broader access to capital would allow us to, I believe, more rapidly get to the point where we can actually provide a stronger level of service and value to our customers.
Q. Is it your testimony that without conversion Premera couldn't do everything it could do in disease management?
A. We will make every effort, our best efforts. But what my statement was is there are specific examples where we believe if we could move some of these programs in-house, we would do a better job and we have evidence of where that is supported that would benefit our --
Q. Premera cannot afford to move these disease management programs in-house, in its non-profit state?
A. Again, it is something that over time we could invest in. As I mentioned, we did move our oncology program in-house, and we evaluate these things, but it is a matter of how quickly we can do it and what scale

can we do it in our current capital state.
Q. Are you aware, Mr. Ancell, what the approximate cost of moving this disease management program in-house for Premera would be?
A. I haven't evaluated it in that detail.
MR. COOPERSMITH: No further questions.
MS. EMERSON: No questions.
JUDGE FINKLE: See you at 2:00 o'clock.
(Lunch recess.)
MR. MITCHELL: We call Brian Kinkead.
JUDGE FINKLE: Please sit down.

BRIAN KINKEAD, having been first duly sworn by the Judge, testified as follows:

DIRECT EXAMINATION

BY MR. MITCHELL:
Q. Mr. Kinkead, would you please state your name and spell it for the record.
A. My name is Brian Kinkead, Kinkead is spelled K-I-N-K-E-A-D.
Q. Mr. Kinkead, have you provided prefiled direct testimony in this matter?
A. I have.

Q. And does your prefiled direct testimony incorporate by reference the Banc of America Securities expert report, dated November 10th, 2003, as well as, the BAS supplemental report dated March 5th, 2004?
A. Yes.
Q. Does your prefiled direct testimony also have attached to it a copy of your current resume?
A. It does.
Q. Have you provided prefiled responsive testimony in this matter, Mr. Kinkead?
A. Yes.
Q. Does your prefiled responsive testimony refer to and have attached to it excerpts from the depositions of John Koplovitz and Michael Alderson Smith?
A. Yes, it does.
Q. Does your prefiled responsive testimony also refer to, and have attached to it as Exhibit B, a comparison of provisions found in Premera's Amended Form A with various precedents, including WellChoice?
A. Yes.
Q. Mr. Kinkead, do you adopt your prefiled direct and responsive testimony in this matter?
A. I do.
MR. MITCHELL: Your Honor, Mr. Kinkead's direct and responsive testimonies, with their exhibits,

have already been filed and served in this matter. With Mr. Kinkead's adoption of that testimony, we move for admission of Exhibits P-75, P-76, P-77, P-78, P-79, P-80 and P-81.

MS. DeLEON: No objection.

MS. HAMBURGER: No objection.

JUDGE FINKLE: Admitted.

Q. Mr. Kinkead, would you please summarize briefly the subject matters of your testimony?

A. Banc of America Securities was asked several questions, including is it appropriate for the company to seek capital from the public markets -- convert to seek capital from the public markets? Will the company be an attractive investment to public investors? Is the structure and terms of the proposed transaction consistent with the -- with what the markets expect and so forth.

Q. Mr. Kinkead, what in your background and experience qualifies you to give testimony in this area?

A. I have been a healthcare investment banker for 20 years now, focused exclusively on healthcare companies and organizations. I have been working with Blue Cross/Blue Shield companies and Vantage Care companies generally since the early '90s.

I have been involved in many Blue Cross/Blue Shield

company transactions, including, most recently, the mutualization and IPO of Anthem, as well as transactions involving such companies as Blue Cross/Blue Shield of Georgia, Healthcare Service Corporation, which has a license for Illinois and Texas, and other companies.

I am a managing director in the healthcare group at Banc of America Securities. I have been with this firm for almost two years now.

Prior to joining Banc of America Securities, I worked for Morgan Stanley for the first 16 years of my investment banking career.

The healthcare group at Banc of America Securities is one of the largest -- we think the largest healthcare groups on Wall Street, with almost 120 professionals firm-wide dedicated to healthcare companies.

The healthcare group at the firm consists of a number of senior mid-level people, dedicated to a variety of different types of healthcare companies, including managed care companies and Blue Cross/Blue Shield companies.

Q. Mr. Kinkead, can you summarize for us, please, your educational background?

A. Yes. I have a Bachelor's degree from Essex University in England. A Master's degree from Leeds University in political science, as well as a second

Master's degree from the same university in healthcare administration, and I have a Doctor of Science degree from Johns Hopkins School of Public Health.

Q. You mentioned, Mr. Kinkead, that there are 120 professionals, or thereabouts, in the Banc of America Securities and Healthcare Group.

Did you utilize the skills and talents of other members of the team besides yourself in this assignment?

A. Yes, I did. The key members of the team, which I led, included John Piesky, who is the vice-president with Banc of America Securities and Healthcare Group. He has been at the firm five years. He has been involved in many transactions involving managed care companies and Blue Cross/Blue Shield companies. Most recently he was involved and really led on a day-to-day basis the IPO for Molina, a Medicaid managed-care company.

We also had an associate on the team, John Hammock, who joined the firm about two years ago, a very good young associate, and an analyst, Shamir Lada, who has been with the firm three years.

Q. Mr. Kinkead, the prefiled responsive testimony that you filed in this matter identifies a number of points of agreement between the OIC staff's investment banking experts or consultants from the Blackstone Group and

yourself. I would like, however, to direct your attention to a couple of paragraphs in Mr. Koplovitz's responsive testimony, in which he comments upon your own testimony.

First, Mr. Koplovitz says that, "If Premera made the proposed modifications detailed in Blackstone's supplemental report, Blackstone believes that Premera's plan taken as a whole would generally be in-line with the plans from previous Blue Cross/Blue Shield conversions." Do you agree with that?

A. No, I do not.

Q. Why not?

A. Well, some of the provisions that they are talking about, in fact, are not consistent with other Blue Cross/Blue Shield transactions, most importantly, the most recent transaction for WellChoice, the New York-based Blue Cross/Blue Shield company.

Q. Let me ask you, Mr. Kinkead, if you would take a look at Exhibit P-81, which was Exhibit B to your prefiled responsive testimony.

Mr. Kinkead, are the provisions of the Amended Form A filed by Premera, without the modifications proposed by Blackstone, consistent with the provisions in prior Blue Cross/Blue Shield conversions, including WellChoice?

A. Yes, they are quite consistent, most especially with the most recent conversion of WellChoice.

Q. Now, Mr. Koplovitz says that if the Blackstone modifications were adopted, not only would the plan, taken as a whole, be in line with plans with prior Blue Cross/Blue Shield conversions, but also the concept of investors ascribing a lower valuation for a plan, a plan that contained other markets -- by which I think he means novel positions -- would not apply.

My question to you, sir, is whether you believe that investors would in fact ascribe a lower valuation to a plan that included the Blackstone-recommended features?

A. Well, yes, I think there is a significant risk that that would happen. Because, as I understand these provisions, they are contrary to what Blue Cross/Blue Shield Association requires of its licensee.

So, to the extent that these provisions would jeopardize the ability of the company to retain the license and use the Blue Cross/Blue Shield mark, that could have quite a significant negative impact on the value of the shares to the foundation and to the public shareholders.

Q. Mr. Koplovitz also observed that many of the proposed modifications in the Blackstone's report are

not intended to enhance the value of Premera's stock to outside investors, but are in fact intended to protect the value of the Washington foundations at stake.

He continues, "In addition, Blackstone does not believe that the proposed modifications would adversely affect the value of Premera to a public investor, assuming that it retained its BCBSA Mark." Would you comment on that, please.

A. Well, I think the first point is the interests of the foundation are very consistent, in terms of value -- protection of value with the interest of the public shareholders.

So to the extent that he says that they are not designed to protect the value for the public shareholders, but protect the value for the foundation, there is an inconsistency there. Because the value of the shares held by the foundation are in fact determined by the market value of those shares in the stock market, i.e., the value of the shares held by the public shareholders.

Q. Well, you comment as well, Mr. Kinkead, upon the concluding sentence in Mr. Koplovitz's testimony, which remarks upon the protection of the value, assuming that Premera retained its BCBSA mark?

A. Well, clearly, the Blue Cross/Blue Shield mark is

critically important to retaining the value. That's the most important premise. So I guess point number one is that that's a very big assumption.

But, point number two, is there are certain provisions that Blackstone has recommended. That, even in the absence of a Blue Cross/Blue Shield license issue, it could have an adverse effect on the value of the shares.

Q. It has been suggested, Mr. Kinkead, that provisions that would increase the amount of flexibility enjoyed by the foundations in disposing of their stock, or that would increase the ability that they have to have influence on the governance of Premera would enhance the value of those shares in the hands of the foundation. Do you agree with that?

A. No, I don't.

Q. Why not?

A. Well, for a couple reasons. One is, the key trade-off here is really making sure that the company is operated in a way that's consistent with public companies generally. And the foundation has interests which are different. They have other interests, apart from the value of the shares. The foundation will have a mission. That mission perhaps is still to be defined. But, to the extent that the foundation had complete,

free control of the board, for example, appointed a majority of the board members, or are able to vote their shares freely, the risk is that the foundation might have interests that would cause the company to have to operate in a way that was inconsistent with the interest of shareholders generally.

So I think this relates to the voting trust investiture agreement in particular, that it is important for the interests of the public shareholders to be protected, vis-a-vis the potential interests of the foundation, particularly insofar as those interests diverge from the interests of the public shareholders.

Q. The point about the voting trust agreement, which appears to be a point of contention between the parties, Mr. Kinkead, is whether the voting trust agreement should survive, even if the marks should disappear from Premera? In other words, if the Blue Shield Association marks are gone, do you believe that it is appropriate to have a voting trust agreement in the circumstances of this transaction, independent of whether Blue Cross/Blue Shield Association requires it?

A. Yes, I do, precisely for the reasons I have just described.

Q. With respect to the interests that you described, that the public shareholders claim to have in making

sure that there was not undue interference with the operations of Premera, would it be your assessment that the interest of the subscribers at Premera would also be aligned with the interest of outside shareholders in that regard?

A. Yes, I do, actually. A company that is a commercial enterprise competes with other health insurers in the marketplace for those subscribers. So it has to be competitive in terms of the value of the products that it offers to the public employers and their employees.

And to the extent that those products don't add value to its subscribers, it is going to be at a disadvantage in the competitive marketplace, it is going to lose market share. And that's going to hurt earnings, which, in turn, will hurt the value of the stock.

Q. Mr. Kinkead, would you please give us an explanation of the concept of dilution and how it plays in this particular transaction.

A. Sure. Well, there is two ways to think about dilution. One is ownership dilution and another is value dilution, if you like. Ownership dilution, for example, occurs in the context of the company contemplating an IPO, where it sells new shares to the public, of what we would call primary shares, primary

issue of shares. So the total number of shares will increase, proceeds will be raised.

So in that regard, the ownership position that the foundation has prior to the IPO, naturally goes down. Percentage of ownership would go from a hundred percent to whatever the ownership position is following the sale of new shares.

But that doesn't necessarily translate to financial or value dilution, for a couple of reasons. One is, from the sale of stock, new proceeds will be raised, so the post-IPO valuation, if you like, will go up by the amount of the proceeds. That's from day one.

But perhaps more importantly, with the proceeds the company -- and with the flexibility that the company will obtain by going public, the company will have the ability to grow, grow its customers, invest in technologies, become more efficient, and create value that way.

So the IPO creates an opportunity by raising proceeds for the company to invest in its business, grow the business, get new subscribers, and create value for everybody, the public shareholders as well as the foundation.

Secondly, by going public, the company is able to establish a public market valuation for the stock and

provides a mechanism by which the value that the foundation holds can in fact be monetized. So in that sense, there is also -- not just an opportunity to create value -- but an opportunity to realize that value through the sale of the stock.

Q. Another concept that we have heard talk of in this proceeding is the concept of a public float. Could you please explain that concept as it is used in the investment banking world and explain how it figures in this particular transaction as well?

A. Sure. Well, the public float is a term used to describe shares held by the public, the public being either institutional investors -- such as pension funds or mutual companies -- as well as individuals or retail investors. And that stock held by those -- that class of investors, institutional investors and retail investors -- is stock that's free to trade in the public market. So if it is a New York Stock Exchange-listed company, that stock would be traded on an ongoing basis on the stock exchange. So that's what we mean by float.

The shares held by the foundation are restricted stock. It is privately-held stock, if you like, and it is not traded in the open market the way the shares are traded, held by institutions and retail investors. So the public float is an important concept, and that's

what it refers to.
Q. Is there a notion, Mr. Kinkead, of a minimum public float or a minimum amount of stock that you want to be traded in the public market for reasons that I hope you will explain?
A. Sure. Well, the issue for investors -- particularly institutional investors, which tend to dominate the markets -- most shares are held by institutional investors, like mutual funds, who hold a stock on behalf of individuals who invest in those mutual funds. Funds like -- Fidelity is the most well-known fund -- they take big positions in stock. They don't just buy a few shares here and there, they will buy a lot of shares.

And they want the ability to be able to buy shares in the marketplace, and also sell shares in the marketplace, without the activity of buying or selling, in and of itself, to cause a change in the value of the stock. So they don't want the stock to go down because they decide to sell two million shares.

In order to avoid that type of phenomenon, there needs to be a lot of trading activity in a particular stock. In order for there to be a lot of trading activity in any particular stock, there has to be a lot of stock in the marketplace for that particular company. If it is a very small public float, the risk is that

when a Fidelity or someone like that sells stock, the act of selling the stock is going to cause the value of the stock to drop significantly. So big institutional investors will stay away from companies that have a very small float.

In terms of what that float needs to be, there is no hard and fast answer. For small, very high-growth companies, like biotech companies, or some of the technology companies that we saw during the Internet boom doesn't necessarily have to be that big of float, because the expectation is that these companies are going to grow very, very quickly, and that float is going to increase quickly over the course of time.

But for the normal companies, which is what I would describe the health insurance company -- or really any company involved in healthcare services -- our view of what kind of -- the minimum float is kind of a hundred million, 120, something like that.

So if you have a float smaller than that, then there is a risk of value, the negative value impact, because big institutional investors will stay away. That, of course, means there is less demand for the stock. If there is less demand for a stock, there is a lower price, same for any other commodity.

Q. So, do I understand you to be saying, independent of

the desire on the part of the foundation to sell stock in order to realize funds, in order to fund charitable activities, independent of the desire Premera might have to sell stock and raise capital for infrastructure rather than improvements, that both of them have an interest in making sure there is an adequate public float?

A. Yes, absolutely. To the extent that the company and the foundation can increase the size of the public float, increase the number of shares that are traded in the stock market, the better it is going to be for the value of that stock.

That's not to say that the fundamentals of the company are not important. But, assuming good fundamentals, having a good float, will enhance the value of the Securities.

Q. I want to ask you a question about having independent divestiture schedules for the two foundations, as opposed to an aggregate foundation divestiture schedule, Mr. Kinkead.

I believe this is one of the topics you treat as a Blue Cross issue, but independent of the Blue Cross issue, are there concerns associated with having independent divestitures?

A. This gets to the issue of orderly monetization of

the holdings of the foundations. Now, the market investors are very comfortable with Blue Cross/Blue Shield companies having foundations that have stock that has to be monetized. And, with all of these prior companies, such as WellPoint and WellChoice, they see very clear divestiture schedules for those companies. So there is a predictability about when that stock is going to come into the market.

The issue about having separate, independent schedules for two large foundation shareholders is the risk, from the public investor standpoint, that shares are coming into the market in a disorderly, even haphazard, fashion. That you have a sale by one state in one month, and a month or two later have a second sale by a second state. That, frankly, doesn't give the stock time to kind of settle and find a natural home with investors. It just puts too much selling pressure -- potentially puts too much selling pressure, I should say -- on the stock.

Q. Quite apart from whether that actually happens, Mr. Kinkead, is there a phenomenon of expectations that might have an impact on value because of the possibility that it might happen?

A. Well, yes, I think there is. If investors can read a schedule, have a pretty good sense of an aggregate,

the foundations are going to settle down their position by 50 percent within three years, for example, they have a -- they know what's going to happen, they have an expectation of what stock is going to come into the marketplace.

To the extent that the schedule is made more complex and more complicated and more difficult for investors to understand, by virtue of having two independent schedules existing, that could have a negative impact on value.

Q. I believe you said, Mr. Kinkead, at the outset, that one of the issues you investigated was whether Premera would be an attractive investment?

A. Yes.

Q. I want you to assume for purposes of my question that the -- that Premera IPO will be done with the transaction terms that are set forth in the Amended Form A.

Do you have an opinion, Mr. Kinkead, as to whether Premera, under the provisions set forth in its Amended Form A, would be an attractive investment?

A. Yeah. I mean, based on current market conditions and the record we have seen historically with other Blue Cross/Blue Shield companies, this company has characteristics that are very similar to Blue Cross/Blue

Shield companies that have gone public before, both in terms of the transaction structure, as well as the business fundamentals.

And, as I think I showed pretty clearly in my report, all of those offerings have been very successful and those stocks have appreciated, and they have paid handsome dividends in terms of higher value, to both the public shareholders, as well as in the case of not-for-profit conversions, to the funds of foundations that were created in connection with the conversions.

Q. Mr. Kinkead, does it make sense for Premera to access the equity markets at this time?

A. Yes, I think it does. Overall, the equity markets have improved significantly in the last 12 to 18 months -- generally speaking they have for companies across the board. But, in particular, healthcare companies have done very well, and there have been a number of very successful offerings for health benefit companies.

Anthem was the most notable example in the fall of 2001. That was the first offering of stock after September 11th and it was a big success. But since then, WellChoice, the New York Blue Cross Company has gone public. That stock was sold, I think, at an opening price of 27 dollars. Today it is trading at 43.

So that's been a home run for the foundation and the public asset fund there.

Molina, a managed care company that focuses on Medicaid, has gone public, and that's been very successful. And there has been a number of secondary offerings by other managed care companies.

So this is a good time. The fundamentals for the industry are good, the equity markets are strong. So, by all means, the company -- if it is going to go public, this is the time to do it.

MR. MITCHELL: Thank you. I have no more questions.

MS. DeLEON: Thank you.

CROSS-EXAMINATION

BY MS. DeLEON:

Q. Good afternoon, Mr. Kinkead.

A. Good afternoon.

Q. I believe you stated in the past that Premera's goal to raise capital was to increase its strategic flexibility and execute its strategic objectives, do you recall?

A. Yes, I do. That's correct.

Q. And you said that was reasonable?

A. Yes, I did.

Q. Reasonable as compared to what?
A. Well, reasonable -- I am not sure I understand the question, I am sorry.
Q. Well, what did you base your opinion on that it was reasonable?
A. Well, it is reasonable in the sense that any company that's -- and this goes beyond healthcare -- but any company that's focused on serving its customers and competing in the marketplace -- in this case, health insurance -- needs to have capital to invest in its business, and it needs to have access to capital on an ongoing basis.

So that's what we mean by strategic flexibility, it is having long-term financial flexibility to invest, grow your business, and continue to be a successful company, as measured by how successful you are with your customers, how that translates into revenue, how that translates into earnings.

So when I say it is reasonable for a company to want to have strategic flexibility, it is because that's kind of the lifeblood of the company. So it is a natural thing for a company to want to have access to capital.
Q. Do you know what Premera's strategic objectives are?
A. I think I have got a general sense of their strategic objectives, yes.

Q. Could you tell us what those are.
A. My understanding of the company's strategic objectives is to continue to develop products, health benefit products, for its subscribers. That requires claims-paying systems and other technologies to support those products. To be able to grow its customers, compete in the marketplace in the sense of competing with other companies in its existing market, not only retaining its market share, but presumably -- hopefully increasing its market share over time.

Expanding potentially into new geographies, growing the company so it achieves the scale. Scales are very important in this business. So I know the company has made investments to grow its business out-of-state, out of the states of Washington and Alaska. So I know that's an important strategic objective of the company as well.

So I would say it is improving -- its strategic objectives are to improve products for its existing customer base, grow its customer base by competing in market, and expanding its customer base and achieving scale by growing in new markets.

Q. Aren't they doing that now?
A. Well, yes, I think they are doing it now. But I think their ability to do it and continue to do it and

do it in a way that's competitive with other major companies that are public, who do have access to capital, depends on the company achieving a structure that allows it to access capital and invest capital in a more aggressive way, as I say, to compete with those other companies which do have access to capital.

Q. So, in other words, they could do it quicker perhaps?

A. They could do it quicker. But let me put it another way, they would have a -- perhaps a better chance of success. I mean, success is not guaranteed, but they would have a better chance of success if they could invest capital more quickly.

Q. Just for your information, I am going to be looking at your supplemental report and 77.

MR. MITCHELL: 78, I believe.

MS. DeLEON: Exhibit P-78.

Q. Specifically, I am on page five, and in the first paragraph, about midway down. I am sorry, are you there?

A. Yes, I am here. Sorry.

Q. You have written that, "The Company's Risk Based Capital ("RBC") levels are among the lowest of the Blue Cross Blue Shield Association licensees and, in certain downside and upside operating scenarios, are projected

to fall below the BCBS early warning requirements."

Can you tell us what the downside scenarios that you referred to are?

A. Well, for example, you know, one downside scenario is where the company grows, obtains new members. As it obtains new members in the marketplace, its capital requirements grow. But as capital levels, its surplus capital may not grow as quickly. The reason for that is it is a very competitive market, you have to basically set your premiums where the market is, and there are certainly plenty of scenarios where margins in this business are compressed.

But the fact of the matter is if you grow your business in health insurance, you need to increase your surplus base. And in circumstances where you can't increase premiums enough to do that on your own because of market factors, you risk having a surplus deficiency, which would cause your risk-based capital position to go down, and could ultimately cause you to be in violation in the case of Blue Cross company with their licensing requirements of the association.

Q. What would the upside scenarios be?

A. Well, an upside scenario -- an upside scenario could be one where -- actually, I guess I should rephrase that. That would be an upside scenario. So you are

growing the company, and as a result, growing the company quickly, but with an inability to increase premiums as much as you would need to maintain the same level of surplus if surplus goes down. I apologize for the confusion.

A downside scenario is one where, for example, where your price competition is increased, premiums are squeezed. Members may stay flat or may be falling. Your operating expenses could be going up, maybe you have got to invest in new claims-paying systems, for example. And, as a result of that, your overall surplus position deteriorates.

So a downside scenario is one where the surplus position of the company deteriorates as a result of increased competition or increased expenses. An upside scenario is one where the company is pursuing a growth opportunity, but as a result of that, needs to invest more capital into its base.

Q. Did you perform any sensitivity studies regarding these scenarios?

A. No. We relied on the analyses prepared by the company, which were, I think, contained in their filings, as well as in the Blackstone -- I think we saw it also in the Blackstone report.

Q. The Premera filings?

A. Yes.
Q. Okay. Do you know what Premera's stated use of the capital is from the proceeds?
A. Well, I think the general purpose is to invest in the business, to invest in the development of products, to invest in systems and technologies to grow the company, to increase the capital base of the company so it is not so close to the edge with respect to the Blue Cross/Blue Shield Association licensing requirements.
Q. Do they have a list of uses at the moment or are these --
A. I don't think they have a specific list that shows by item how much is going to be spent over what time period. I think it is a general -- a more general objective to increase the capital base of the company so that it is in line with the requirements -- more in line with the requirements of the association, as well as to give the company the flexibility to invest in the products and customer service.
Q. Do you know what Premera is going to do immediately with the money? Are they going to invest it --
A. Yes. Presumably they would -- that would be natural, and that would be typical for companies that raise primary capital. They don't spend it all on day one. Their objective is to raise capital that will

suffice for a period of time, whether that is six months, a year, two years or more.

And in the intervening period, obviously they don't want to take risks. So they don't want to put the money, for example, in stocks or commodities, they want to be very conservative.

So typically a company, particularly an insurance company, particularly where it is using the proceeds to help build surplus, would invest in very highly-rated money market securities or even cash.

Q. Do you know what the investment rate would be on that?

A. Well, today it would be pretty low. It would be two or three percent at best.

Q. Could you tell me what the least expensive form of capital is?

A. The least expensive form of capital? Well, the least expensive form of permanent capital is -- is, frankly, equity. Debt capital, particularly for a small company like this, can be extremely expensive.

For a much bigger company that capital is a -- is probably more attractive than equity. But for a small company that's just converting, doesn't have ready access to the markets, equity capital is really the only viable alternative.

Q. But isn't equity capital also expensive to the company?
A. Yeah. Well -- yeah, I mean, it requires the company to produce a return for its investors for sure. So that's what I say -- for a big company, you take like the United Healthcare, for example, the largest health insurance company, if it is going to go out and raise capital, it is probably going to use a debt market, because it can easily access debt capital at fairly attractive rates, five or six percent.

But for a small company like this, particularly with a low rating, that source of capital is just not available to it.

Q. Do you know what the cost of -- to Premera of issuing the equity would be?
A. Well, it is not like a -- there is no percentage to it, okay? So the cost of capital to Premera doesn't have a coupon attached to it. Investors are going to expect this company to grow earnings and for the stock to appreciate.

And when they look at this company, in comparison to other health insurance companies and based on their own due diligence of this company, they are going to expect this company to grow at that sort of levels.

Those companies, other Blue Cross/Blue Shield

companies, other managed care companies, are growing earnings on a long-term level of between 10 and 15 percent a year -- more closer to 15 percent a year.

So, if you like, that's kind of the cost of capital, somewhere between 10 and 15 percent. The market expects -- will expect when these securities are initially priced, for the company to grow at those sorts of levels.

Q. So if it costs Premera 10 or 15 percent for this equity capital that they are receiving --

A. Uh-huh.

Q. -- and they invest at four percent --

A. Uh-huh.

Q. Why would you do that?

A. Well, certainly wouldn't do that if you were investing at four percent for the long term. There may be reasons, as I said before, you want a public trading in the securities so that the owners can -- so it is a vehicle for owners to liquidate their stock.

But the reality is -- as I described, that's simply where you kind of park the money, if you like, after you go public. You don't spend the money day one when you go public. It is not -- if you raise a hundred million dollars, you are not investing a hundred million dollars the next day in all of the things I described.

Over the course of 6, 12, 18 months, whatever that period is, the company would invest in those systems, would invest in growing its business in new markets and so forth, and would do so in a way that creates much greater earnings growth potential than the company has today. And, appropriately, the company would take a long-term due. So when I say long term, I mean more than 6, 12, 18 months, sort of 2, 3, 4, 5 years.

So the expectation that the -- presumably the company would have -- certainly investors would have is -- and the foundation should have -- is that, in the long term, this is going to create value for these shareholders. And that earnings aren't going to be diluted by this low return that the company is getting for the initial period that it is preserving its capital to invest, but in fact that the growth of the company is going to be improved, and that the company -- if its baseline is a 10 to 15 percent return, that the return on investment will be even greater as a result by -- of the investment in these moneys and to systems and expanding the company's business.

Q. You used "if" a lot, didn't you? What is Premera's current operating margin, do you know?

A. I know -- I don't know exactly what its current operating margin is, but I know its margin is in the low

single digits -- or it was at the period that we looked at for the preparation of our report.

Q. Do you know what Premera's projected growth rate is?

A. It is in my report. And if you would like me to refer to the Amended Form A projections that are contained in the report, I can answer that question. But I do recall that the growth rate of the company was in the range that I described for managed care companies generally.

Q. Would it surprise you to say about 20 percent?

A. If it was 20 percent in the first couple of years, coming right out of the IPO, that wouldn't be a huge surprise. But I would expect, looking at longer-term projections, it would probably be something less than that.

Q. Isn't a merger or a sale for stock another option for Premera to get capital?

A. Well, I think there is a couple of issues with that. One, is that I don't think it is the board's objective to sell the company and for the company to become part of a nationally-based company and not be locally owned and controlled, and that's a reasonable objective for any board to have.

But I would say also that with a company like this it has such good growth potential, and so much

opportunity, therefore, to create the value for shareholders in the future.

From just a standpoint of what's the appropriate thing to do for shareholders, it would be -- they would be leaving a lot of money on the table, if you like, if they were to say it doesn't matter about local control, local management, let's just sell the company today. That would be a mistake in my judgment.

Q. Why would it be leaving a lot of money on the table?

A. Because the company today, for example, operates at a very low margin. There is an opportunity for this company to grow its top line. There is an opportunity for the company to improve its margin. So all of that would translate into greater earnings. And companies' values are based on -- in multiple of their earnings.

So if you can -- by putting some capital into the company and improving its operating performance, and thereby create value for shareholders -- public shareholders and for the foundation -- then everyone is going to be better off in the long run. Without doing that, by just selling the company today, you lose that opportunity.

Q. But if the company is looking for capital, isn't sale for stock an option?

A. Well, it is an option, but it is not a very

attractive option.
Q. To the board or to the company itself?
A. Well, to neither, nor to the ultimate beneficiaries, to shareholders, in this case the foundation's.
Q. Why wouldn't it be a benefit to the foundation? It would be less risky than an IPO, would it not?
A. I am not sure that it would be less risky. I mean, there is plenty of examples where companies try to sell themselves and don't get sold and the process breaks down.

Selling a company, in fact, can be an extremely risky process. It is obviously a huge distraction for employees. It can cause the company's operating performance to deteriorate. So there is actually a lot of risk associated with M&A transactions.

In contrast, when you look at the track record of IPOs of managed care companies over the last 13 or 14 years, every one them has been successful. Every single one of them -- in every single case, the value of the stock has appreciated significantly in the years following the IPO.
Q. How many publicly-traded Blues companies are out there now?
A. There are three publicly-traded Blues companies in the market today.

Q. Isn't WellPoint actually being merged with Anthem?
A. Yes. They announced a merger with Anthem in the fall. That merger is expected to be completed in the end of June, early July. So, following that, there will be two Blues companies.
Q. You stated that -- if Premera should lose the mark, the restrictions and the voting trust divestiture agreement should remain; is that correct?
A. Yes, that's correct.
Q. Didn't the WellChoice deal include a provision where the restrictions went away?
A. It may have. I would have to refer to my document. But, whether it did or it didn't, wouldn't change my view. I think, fundamentally, it makes sense for that provision to stay in place for the reasons that I described.
Q. Well -- did WellChoice stock do well to your knowledge?
A. Yes, WellChoice stock has done well.
Q. Well, doesn't that mean the investors were comfortable with the removal of their restrictions if the mark was lost?
A. It is a hypothetical. I can't tell you how the stock would have performed post-IPO had that provision been in there. There is lots of little different

nuances, obviously, associated with any transaction.
Q. Do you know if the divestitures schedule is a BCBS licensee requirement?
A. Yes. The Association has a requirement that large shareholders monetize their holdings over a reasonable period of time. And these provisions have been established as precedents over the years, beginning with WellPoint, following its restructuring I think in 1996.
Q. These are conditions, I understand, from the association, but are they actually part of the licensee agreement? Were they set out in the schedule per se?
A. I don't know if they are incorporated directly into the actual legal document that forms the licensing agreement. But I do know that the association establishes certain rules, and the rules governing those licensing agreements can be changed by the association if the association's board chooses to change something.
So my understanding is that these requirements that the association has put in place over the years do, very much, affect the license. And if you don't abide by these provisions, you can lose your license.
Q. I believe you stated that the foundation may have a mission that may be different or goals that are different from the company; is that correct?
A. Yeah. I explained that investors want to be

protected from a situation where a foundation could take a track which was contrary to the interests of the company and to the public shareholders.

So I didn't say that the foundation did, I said the investors want protection against that eventuality, that possibility.

Q. But the foundation -- a hundred percent of the amount of the capital it receives basically hangs on the value of its stock; is that correct?

A. Initially, yes, that's correct.

Q. Why wouldn't the foundation want the stock to be at the highest price possible?

A. Yeah. Well, I think the foundation would, but I think what investors are concerned about is that the foundations that might have competing objectives, if you like. So, on one hand, for sure it would want the value of its holdings to be at the highest possible level. But it is also conceivable that the foundation would have a mission or to take a position that it wanted health insurance to be sold at below-market premiums.

I am just, again, speaking in hypotheticals. But let's say, hypothetically, -- because, again, we are just talking -- what investors want is protection against the hypotheticals.

So hypothetically, the foundation could want health

insurance sold at below-market rates so -- for whatever reason, wanted to promote the sale of health insurance in the State of Washington -- well, that would be a competing objective.

So presumably at the board of the foundation there would be a debate about it. But how that turns out, it could go either way. There are -- one can certainly envision scenarios where a board of a foundation could take the view that the overriding objective of the foundation is to make sure that health insurance is sold at the lowest possible cost, and if that involves selling it at below-market rates, so be it.

So in that scenario, if there are no controls on the votes of the foundation, the foundation ultimately could force the company to do that, and that would cause the performance of the company to deteriorate and the value of the shares to fall.

Q. Have you actually encountered the scenario?

A. No. I haven't encountered it, but this is the reason that the market has wanted to have voting trust divestiture agreements associated with not-for-profit foundations, associated with not-for-profit companies that are converting to for-profit companies. They want to make sure that the companies operate in a way that's consistent with the marketplace.

Q. I understand that the WellChoice transaction did not have the requirement that the foundation reduce their holdings to less than 80 percent in the first year. Is that also to your knowledge, too?
A. Well, they sold at the initial public offering enough shares such that they were below 80 percent anyway. So I think it was, I think, a moot point.
Q. You recommend that in Premera's case the foundation be required to reduce its holding to 80 percent in the first year?
A. Yes. Yeah, for the reasons I described earlier, about the need to make sure that there is an adequate public float, adequate number of shares held by institutional investors. It would certainly make sense for the company to have 20 percent of its value in year one in the public market.
Q. Doesn't Premera have a year to implement their IPO?
A. Does it have a year to implement its IPO, you mean, from today? I am sorry.
Q. They have a year's window on which to do their IPO?
A. From the date of conversion?
Q. Yes.
A. Yes. I believe they have timing flexibility in that regard.
Q. After the IPO, isn't it possible that the foundation

could still own 80 percent of the stock?
A. After the IPO? Yes, that is possible.
Q. Isn't it also true that after the IPO there is a 180-day window where they would be restricted from selling their stock?
A. That's correct.
Q. So that would leave only six months for the foundation to sell whatever stock it had to get to the 80 percent level; isn't that true?
A. That is correct.
Q. Aren't there also periods of time when the stock market is adverse to selling of stock?
A. Well, yes, there have certainly been circumstances when market conditions haven't been good to sell stock, that's for sure.
Q. Post-911 was a good example?
A. Actually, you know, interestingly enough, Anthem did its IPO in October of 2001, that was the first IPO done after September 11th, and it was a huge success.
Q. After the IPO, the foundation can't sell any stock for six months, because of the 180-day restriction, that leaves only six months for it to sell down to the 80 percent mark. And if, within that six-month window, there is also a time where it is adverse to sell stock in the market, wouldn't the divestiture schedule force

the foundation to sell during this adverse time?
A. Well, I think if the foundation was concerned about that, it does have the opportunity at the time of the IPO. Say, for example, the company is selling primary shares that in effect would result in the foundations collectively having 85 percent post-IPO, the foundations could -- if they were concerned about that risk -- use the IPO to sell some of their own shares, such that they would avoid -- if they were concerned about it -- the risk that in that six-month period, at the end of year one, that they would have -- it would have adverse market conditions. So that would be one option.

Another option -- if they didn't choose to do that, as I understand the provision -- is the company -- if the foundations issue a demand right to sell stock into the market, the company has the option of buying the stock from the foundation based on recent closing prices for the stock in the public market.

So there are -- you know, there are alternatives to that. Sell at the IPO, if they are concerned about that risk. Or if they don't want to sell at the IPO, sell it to the company.

Q. Is another option just to remove that restriction and let them -- and take the one-year requirement away?
A. That is an option, but it is a question of how does

that effect the company's ability to retain its Blue Cross/Blue Shield mark? And how does that affect the company's objective, which I think is consistent with the foundation's objective of making sure that the public float, the number of shares held by institutional and retail investors, is adequate to support stock trading.

Q. In your report you do say though on page 12 --

MR. MITCHELL: Report or supplemental?

MS. DeLEON: Supplemental. I am just doing supplemental.

Q. That if the foundation lets Premera sell primary capital in the IPO and waits to sell secondary shares in a following offering, they might get better value?

A. Uh-huh.

Q. But if they had the six-month timeframe to do it, they might not be able to take advantage of that?

A. Right. Well, we are talking about a relatively small amount of shares here I think, based on my understanding of what's contemplated.

And the hypothetical example I used just now, we are talking like five percent of the total holdings of the stock outstanding post-IPO. So we are talking about a relatively small amount of total holdings.

I did say and I agree -- continue to agree -- that

there is a lot of value appreciation associated with this stock. But it is also important for that value appreciation to be realized, as well as for the foundation to be able to sell stock into the public market, in the least disruptive way, to get that public float up as quickly as we can.

So they were somewhat competing objectives, I appreciate, but at the end of the day it is important to get that quota.

Q. Will Banc of America Securities be involved in the IPO?

A. There is no expectation that we will.

Q. Will Banc of America Securities be seeking investment banking services from Premera after the IPO?

A. We will be seeking investment banking services from Premera, the Washington Foundation and the Alaska Foundation. This is a great opportunity, obviously, to be involved in the sale of securities, as well as, providing advice.

So we would be delighted to have that opportunity, but there is no assurance or commitment today for either the foundations or the company that that would be the case.

Q. Have you helped Premera come up with rationale for their conversion?

A. To help them come up with a business rationale for their conversion?
Q. Yes.
A. No. The only thing I have discussed with Premera is that an IPO is a better way to access capital than, for example, surplus notes.
So, in that sense, I have explained the difference in the limitations associated with the use of surplus notes, but I have not been involved in their business rationale for conversion.
Q. Premera has testified it is contemplating between a 150 and 170 million dollar IPO. Have you heard that?
MR. MITCHELL: Object to the question as assuming facts not in evidence, and in fact, contrary to the Form A.
JUDGE FINKLE: Well, just ask the question directly. I am not sure that it is accurate. But just ask it directly, as opposed to making that a part of your question, or refer to a specific document.
Q. Is Premera contemplating a 150 to 170 million dollar IPO?
A. I don't know.
Q. Assuming it was 150 million, would that be dilutive to the foundation?
A. Not in the long run. I don't believe so, no.

Q. Why not?
A. Well, for the reasons I described earlier. Yes, from day one, when you put the money into the bank, it is dilutive that day, from an economic standpoint. So if you measure it over the first few months, yes, for sure, it is dilutive.

But again, going back to the explanation I gave earlier, the moneys are going to be used in the company's business plan, as I understand it, to grow the business, invest in new products, compete for new customers, expand in geography.

In all those different ways, that's going to enhance the earnings of the company and therefore enhance the value of the shares.

So it will in fact be a value-creation opportunity for shareholders, it won't be dilutive, it will be accretive.

Q. In the long run, it won't be dilutive. But on day one, it would be dilutive?
A. Yeah, as in the case of every IPO. If every IPO was decided on whether it was accretive or dilutive on day one, we would never see an IPO.
Q. That would be a dilution of the ownership; correct?
A. I am speaking of -- there is dilution of ownership, but I am also speaking about dilution to earnings.

Earnings on a per share basis will go down typically in an IPO until the moneys are re-invested in the business or used for acquisition or whatever strategic purpose they are used for.

Q. Is there value dilution?

A. That's what I am referring to. When I say dilution to earnings per share, there is the risk of short-term earnings dilution, and therefore the risk of short-term value dilution in a theoretical sense.

The reality though is if you look at any of the Blue Cross/Blue Shield companies that have gone public, they have all had moneys that have sat on their balance sheet for a period of time before they use those moneys. So, in every case, there has been some near-term earnings dilution.

But, in every case, if you look at what the stock has done following the IPO, the stock has gone up. Even if it hasn't gone up -- in the case of like Trigon or RightCHOICE didn't go up very much in the first six months or so, it went up a lot afterwards.

In the case of WellChoice, the stock actually went down, some immediately after the IPO opened up 27, I think it went down as low as 21 dollars or 20 dollars in February. But when I last looked the other day, it was trading at 43 dollars.

Q. Did you ever discuss with Premera the risks of converting?
A. No, I don't believe so.
Q. Do you know what the risks would be?
A. I am not sure what you mean by the risk. You mean the business risk, the risk of a failed IPO?
Q. Right. Business risk, failed IPO being bought up by another company.
A. Well, I haven't discussed that with the company to my recollection. Again, looking at the track record of the companies in this area that have gone public, in the good market conditions we have today as I described earlier, I don't see the risk of a failed IPO to be significant at all. I would see it as immaterial.

You alluded to a risk of a takeover. I think that's also a highly-remote risk, because that implies that somebody would make an unfriendly or hostile takeover attempt of the company. And that's -- you just don't see that, frankly, in the world of insurance generally. In the world of health insurance, it is certainly not in the world of the Blue Cross/Blue Shield Association for various reasons. The companies need regulatory approvals, hostile transactions historically have not been viewed favorably by insurance commissioners.

Secondly, within the world of the Blue Cross/Blue

Shield Association, it would be an enormous risk, if a nonBlue company acquired this company it would lose its license. But even if a Blue company tried to acquire it in a hostile fashion, that company would likely be sanctioned by the Blue Cross/Blue Shield Association.

So I would view the risk of a company like this becoming the target of a hostile takeover by virtue of simply going public as to be remote.

Q. Okay.

MS. DeLEON: That's all I have. Thank you.

JUDGE FINKLE: Thank you.

MS. HAMBURGER: I have no questions.

JUDGE FINKLE: Redirect?

MR. MITCHELL: I think there is brief redirect, Your Honor.

REDIRECT EXAMINATION

BY MR. MITCHELL:

Q. Mr. Kinkead, Ms. DeLeon asked you about the possibility of a merger or the sale of the company as an alternative to the proposed conversion IPO.

Do you have an understanding as to whether or not if the merger or sale were to a for-profit entity, whether conversion would be necessary for that as well?

A. Yes, it would be necessary.

Q. Are there downsides from a public policy perspective, as well as from the company's perspective, to a merger with an in-state provider of health insurance products?
A. Well, the local influence and control of the company would be affected by a sale of the company to -- a large company, which would presumably be an out-of-state company.
So that would be -- if that's what you mean by public policy, yes, it would be loss of local control and influence.
Q. Is there any indication from your review of this company, Mr. Kinkead, that the company needs a different management than it currently has to operate a successful company?
A. No, there is no indication to that, in fact, to the contrary. The results of the company have been improving in recent years, which is a validation of management, in both its operating skills and the strategic direction it has been moving in the company.
Q. There was a question about the possibility of the board of the foundation exercising control over Premera if there were not a voting trust in the divestiture agreement in place. Do you recall that question?
A. Yes.

Q. Do you have any reason to believe that the members of the board of directors, of the proposed Washington foundation, will have had any experience or skill in running an insurance company?
A. No, I don't know. I wouldn't expect that they would.
Q. Would you have a reason for concern based upon that expectation as to the potential impact on the subscribers of the insurance company, if people who had no experience or skill in it were running the company?
A. I think there would be a higher risk if the company was not operated appropriately for a health benefit company if no one on the board had experience operating an insurance company or operating a company that's involved in financial services of some sort or another to subscribers or customers.
Q. There were a number of questions that were posed to you, Mr. Kinkead, about the possibility of the foundation being stuck needing to sell stock in the last six months of the first year following the IPO. Do you recall those questions?
A. Yes, I do.
Q. If the company issued enough shares at the IPO to constitute 20 percent of the market, would the foundations need to sell a single share in order to be

at 80 percent of holdings at the end of the first year?
A. I am sorry, could you repeat the question.
Q. Sure. If the size of the IPO were equivalent to 20 percent of the market?
A. Uh-huh.
Q. Would the foundations need to sell a single share in order to meet the 80 percent in one year requirement?
A. No.
Q. If the company had an IPO of that magnitude, would you believe it would be sufficient to generate a public float that would be adequate for the company in a foundational light?
A. Yes, I think so. Because, as I said earlier, the minimum is a hundred million or so. And I think -- while no evaluation has been put on the company -- that sounds like it would get -- do above a hundred million.
Q. If you had an adequate public float under those circumstances, Mr. Kinkead, do you have reason to believe that the foundations would have difficulty selling a secondary offering in years two or three?
A. No, I don't believe they would have difficulty selling.
Q. Ms. DeLeon asked you whether you had an expectation as to whether Banc of America Securities would participate in the forthcoming IPO if the conversion was

approved, and I believe you said you did not. Are you aware of the investment banking firm that is in line to handle that for Premera?

A. Yes, I am.

Q. Who is that?

A. If I understand it, Goldman Sachs is the advisor to the company.

MR. MITCHELL: Nothing further. Thank you.

MS. DeLEON: I just have one question.

RECROSS EXAMINATION

BY MS. DeLEON:

Q. If the foundation doesn't sell any shares within the first year, other than a loan or a grant that it has received from Premera, where would its operating income come from?

A. If the foundation doesn't sell any shares, so it doesn't have any cash. In other words --

Q. Correct.

A. -- on its balance sheet where would it obtain funds to support its staff and so forth? Is that what you mean?

Q. Yeah.

A. If it didn't sell any shares and didn't take a loan, I am not sure where it would get the cash, the funds to

support. Unless it had some other -- some other contributor to the foundation, I am not aware of any other way it could get any cash to pay for its expenses until it did sell shares.

MS. DeLEON: Thank you. No further questions.

MS. HAMBURGER: No further questions.

JUDGE FINKLE: Anything further?

MR. MITCHELL: Not from us.

EXAMINATION

BY COMMISSIONER KREIDLER:

Q. Mr. Kinkead, I was wondering, in the last 10 years are you aware of any Blues plan that lost the Blues trademark, let's say, in the last 10 years? If so, under what circumstance did that take place?

A. Blue Cross of Ohio lost its license. It was in the late '90s I think, of '96 or 1997. Would you like me to describe the circumstances?

Q. Please.

A. I am speaking from memory, so, forgive me, I don't have all the details. But the company proposed to enter into a transaction where it would be sold to a hospital company -- Columbia HCA, I think, was the proposed buyer -- and chose to ignore the admonishment of the

Association not to do that.

And even though the company ultimately was not sold to Columbia HCA and remained an independent company, because they ignored the request of the Association not to proceed down that track, their license was pulled, and it was granted to the other Ohio-based Blue, which happens to be Anthem.

And Anthem now has Blue Cross of Ohio and the license for northern Ohio, Cleveland area. Anthem has the license for southern Ohio, Cincinnati area. And Anthem was given the license for northern -- of the entire state, as a result of that.

That's the only example I can think of, Commissioner, in a recent period when the license was pulled.

COMMISSIONER KREIDLER: Thank you.

MR. MITCHELL: Quick follow-up, Mr. Kinkead.

FURTHER REDIRECT EXAMINATION

BY MR. MITCHELL:

Q. In the example you gave, was there a court challenge to the right of the Association to strip the Ohio Blue plant of its license?

A. I am not sure. It has been -- it was eight years ago, so I am not -- I don't remember all the details of

the case. There may or may not have been.
Q. In any case, did the stripping stand? There was no giving back the license later on?
A. No. The company, to this day -- it was never able to get its license back. And I don't know if it pursued it in court or not, but Anthem has that license today. The company still exists, but it doesn't have the Blue Cross/Blue Shield license.

MR. MITCHELL: Thank you.

MS. HAMBURGER: I just have a quick follow-up question to that.

CROSS-EXAMINATION

BY MS. HAMBURGER:
Q. Weren't there many other problems with the proposal in Ohio, other than just simply selling to Anthem?
A. Yeah. I think there were some other issues about how --
Q. I am sorry, Columbia HCA, I apologize.
A. Yeah. I think there were some other issues, but I think the proposed sale of the company was the catalyst that led to a whole other series of issues arising, that ultimately were included in the Association's deliberations.
Q. It included the board and the attorney for the

company and the top executives being granted non-compete contracts; isn't that right?

A. Yes. I think there was some issues around how the board was operated and so forth, yes.

MS. HAMBURGER: Thank you.

THE WITNESS: That's correct.

JUDGE FINKLE: Any follow-up?

MR. MITCHELL: May the witness be excused?

JUDGE FINKLE: Please step down. You may be excused. We may be a few minutes early, but let's take a break.

(Afternoon recess.)

JUDGE FINKLE: Let's resume.

MS. EMERSON: At this time Premera calls Dr. Roki Chauhan.

Rakesh Chauhan, having been first duly sworn by the Judge, testified as follows:

DIRECT EXAMINATION

BY MS. EMERSON:

Q. Can you please state your full name and spell it for the record.

A. My name is Roki Chauhan. My given name is Rakesh,

middle name Tarun, T-A-R-U-N, Chauhan, so I will spell it all. Roki is R-O-K-I, Chauhan, C-H-A-U-H-A-N. My given name Rakesh, R-A-K-E-S-H, middle name, T-A-R-U-N.

Q. Who is your employer and what is your position?

A. Premera Blue Cross. I am vice-president of medical services and medical director for quality.

Q. What are your responsibilities at Premera?

A. I am involved in the strategic planning and implementation and care facilitation programs, medical policy implementation, and clinical quality problems. I also oversee the activities of the medical directors.

Q. Can you give us an overview of your professional background prior to your current position at Premera?

A. Yes. I am a board certified family physician. I was in private practice in the Bay Area for approximately 10 years, moved to the Seattle area in 1992, also as a family physician. I gradually began to do more and more administrative work.

I was the old-fashioned kind of family physician in terms of doing inpatient care, outpatient care, obstetrics, assisting in surgery, and little by little began taking on more and more administrative roles.

I had a realization one day what I really wanted to be doing was to have a bigger impact, and I felt I had the opportunity to do so -- not in a small practice

setting, where people may take care of approximately 2000 patients -- but broader than that, and my current role affords me that opportunity.

Q. Did you practice in a clinic setting or as a solo practitioner?

A. Initially, I was in practice in a two-person group. We gradually expanded to a five-person group, and that was when I was down in California. And then when I moved to Seattle I took a position with PacMed Clinics, which was a multi-specialty group at the time of approximately 130 physicians.

Q. Can you describe for us your educational background, please?

A. Yes. I received a Bachelor of Science in biology from MIT in 1974. I obtained my medical degree from Tufts Medical School in Boston in 1978. I completed a residency and fellowship in family practice at the University of California, San Francisco, at its Santa Rosa site.

Q. Are you a member of any professional organizations?

A. Yes, I am. I am a fellow of the American Academy of Family Physicians, and I am a member of the American College of Physician Executives.

Q. You mentioned the fellowship, can you describe your fellowships for us, please?

A. Yes. The fellowship I was referring to a minute ago was a fellowship in family practice that involved both teaching, as well as clinical work.

Subsequently, as I made the transition from clinical care, I took a one-year fellowship in managed care through the American Association of Health Plans, and that was in 1997.

Q. Why did you leave your medical practice to work for a health plan?

A. As I hinted at earlier, I felt that I needed to be able to put additional tools in the hands of patients or members and also physicians.

I made a realization one day that I was having an impact in my practice -- and I loved what I was doing, I really enjoyed my practice -- but I found that it was very difficult for individuals to make healthcare decisions based on information that would enable them to take a more active role in their healthcare.

At the same time, as a practicing physician I discovered that in my practice it was challenging to be able to recall members, to have patients come back when it was necessary to get the various testing or follow-up examinations, etcetera. And I realized that in order to do that you need to have access to data and information and have systems in place that would enable that, to be

able to get individuals back in to have their follow-up tests or visits or things like that.

Q. Dr. Chauhan, your prefiled direct and prefiled testimony have been filed and served in these proceedings. Do you adopt that testimony?

A. Yes, I do.

MS. EMERSON: Dr. Chauhan's prefiled direct and responsive testimony have been marked as Premera Exhibits P-40 and P-41 respectively. With the adoption of that testimony Premera now moves to admit these exhibits.

MR. HAMJE: No objection.

MS. HAMBURGER: No objection.

JUDGE FINKLE: Admitted.

BY MS. EMERSON:

Q. Dr. Chauhan, you mentioned that you work on the care facilitation programs at Premera. Can you describe for us the objectives of those programs, please?

A. The primary objective is to provide access to high-quality care for our members, and we have a variety of programs that address that.

Q. Can you describe for us those programs?

A. Yes. We have care management programs, which includes case management, disease management programs, health awareness education programs, and pharmacy

programs.
Q. Do these care facilitation programs address patient utilization?
A. They do, but perhaps not in the way that most people think of it. What I think is unique about Premera is we do not adopt the old-fashioned utilization management, medical management, the mother-may-I approach to managing care.
Instead -- and as a result, we changed our name from Medical Management, back in 2000, to Care Facilitation. Because we really truly believe that we facilitate care and we facilitate high quality care for our members. And at the same time, by doing so, that controls utilization.
Q. When were the Premera care facilitation programs implemented?
A. In their current status -- in their current state, I guess, one would say that they started in early 2000. They have continued to change and grow since that time.
Q. You mentioned a number of components of the care facilitation program. Let's focus first on disease management. Can you explain for the Commissioner how the disease management program works?
A. Yes. Disease management is geared -- aimed towards populations of people with a certain condition. So

diabetes is an example. And the programs are based on putting information in the hands of our members so that they can make informed decisions about the care that they receive.

Our programs are all member focused. They are all geared towards augmenting and improving the doctor-patient relationship. We do not believe in hassling physicians and dictating to physicians how they practice medicine.

However, we also know at the same time that when someone goes to the doctor's office there is a gap between their doctor visits, and in that period of time people sometimes may forget or they may misinterpret or may not completely understand information that's been given to them by their physician. So our programs are geared towards individuals to help them better understand their condition.

So if we use diabetes as an example, we would send out targeted mailings to all the members who have diabetes. I would say that 85 percent of those members are under care, and they are receiving the appropriate tests, and they are doing all the things they should be doing -- i.e., diet, exercise, perhaps medications, etcetera.

But a small percentage of people may forget -- or

may not remember or lead busy lives and not get around to it -- obtaining a test or a follow-up visit. If that happens, then we have ways of helping them remember, reminding them about -- for example, a diabetic eye exam, to make sure that's being properly done on an annual basis, so we can hopefully prevent some of the complications that may happen.

In a smaller percentage of people, they have ended up, unfortunately, in the emergency room or had to be hospitalized because of their condition. And for that smaller percentage of patients, then the disease management programs act more like case management programs, where it is more individualized involvement of a nurse.

Q. You mentioned diabetes as one of the focuses of the disease management programs. Can you give us an idea of some of the other kinds of diseases that fall within that program?

A. Our current programs include, as mentioned, diabetes. We have programs for heart disease, breast and lung cancer, and stage renal disease, and asthma.

Q. You also mentioned case management as another focus or another component of the care facilitation program. Can you explain for us how the case management program works?

A. Yes, I can. Case management, unlike disease management, is more individual focused. So a member has been identified with a complex or possibly catastrophic condition. And a nurse at Premera will become involved in the care of that patient in the sense that they are working with the hospital, the physician or physicians, the member and the member's family, to help them navigate through the complicated world of healthcare.

Q. Can you provide an example?

A. We have several examples. One of the best examples was a member of ours who was a 20-something-year-old individual, who was overseas, and was involved in a -- he was in a rugby tournament and he had a -- he broke his neck. He was, unfortunately, paralyzed from the neck down. He was initially seen at a smaller facility close to where the accident occurred and was subsequently transferred to a higher level of care, still in Australia.

Our case managers got involved because we got notification that this accident had unfortunately happened. Our case manager was in daily contact with the member's family, the nurses, the doctors who were taking care of this individual.

And our ultimate goal was to get him back to Washington, to be with his family, and to be treated at

a facility close to home.

Over a period of time, his condition stabilized, he was unfortunately paralyzed, and they had to arrange a transport for this individual. And surprisingly -- or maybe not surprisingly -- it was very expensive to do this. The case managers got involved in the case and were able to get the air transport donated free by the airline to transport, not only the member, but a team of nurses, a physician and others, to the United States -- first to California and then from California up to Seattle -- so that he could be admitted to a rehabilitation facility closer to his home.

We have countless other examples like that, but that was one of the most striking ones.

Q. What about the other programs you mentioned? I think the third one was the health awareness education program. How does that program work?

A. Health awareness education is targeted towards an even broader population of people. The goal there, again, is to get information into the hands of individuals who can use it, to better understand -- even if they are healthy -- things they might want to do to maintain their health, or if they have some concerns or illnesses or conditions, to gain even more information about it, and we do it in a number of ways.

We have information available on our website. So when you go to premera.com you can go to healthy advantage, and you can find out information about any condition that you would like.

In addition, we have targeted mailings to individuals. Those are often in the forms of reminders. For example, childhood and adolescent immunizations, or reminders to get your flu shot, reminders to get cancer screening tests.

And then another program that we have is a 24-hour nurse line that's available to our members. So that if someone had a question in the middle of the night -- a classic example is a child might have a fever and is keeping the parents up at night. And they are trying to decide, do I take the child to the emergency room, do I call a doctor, what do I do?

When I was in practice, people would call me in the middle of the night. Nowadays, people don't call physicians at night as often for a variety of reasons. And having this 24-hour nurse line available to them, to help them better understand is this something that could wait until the morning, or do I really need to go to the emergency room or urgent care center tonight.

Q. The last program you mentioned was the pharmacy program. Can you describe that program for us, please?

A. We have a couple of programs in the area of pharmacy. The one that has the -- I would say the greatest impact on members is our poly-pharmacy program. This is a program that began approximately two years ago.

We realized that people who are taking five or more chronic medications were at higher risk for having a problem or a complication from them. And we also realized that, in today's world, oftentimes people will go to more than one physician, and they may forget to tell the person that they are seeing that they are on medications that somebody else may have prescribed.

Our poly-pharmacy program was -- it is a targeted mailing with a brown paper bag, and it basically asks the member that the next time you go to your doctor, put all of your medications, including your over-the-counter medications or herbal remedies into the bag and take it with you to the doctor's office and talk to them, review your medications.

Initially, when we first started this program, patients went into their doctor's offices, and within a short period of time, we found we were having an impact. One in four members were having a medication changed. There was either a dosage added or a dosage increased, a medication added or a medication taken away.

Again, we didn't say whether being on five or more medications was right or wrong, we just said talk to your doctor. And this program has now been in place for a little over two years, and we have reached 48,000 members.

Q. Is there also a generic drug component to the pharmacy program?

A. There is. I think everybody is concerned about the cost of medications, pharmaceuticals. And one of the things that we have been working on, both with the physician community, the employer community, as well as members, is to encourage the prescribing of generic medications.

This is entirely voluntary, like all of our other programs. But what we found was that, by providing information to people, they can again make intelligent decisions about their healthcare.

One of the aspects of the program is that physicians, oftentimes, when they first prescribe something go to their sample cabinet, and they will have the current, latest version of a medication.

And in many cases, they are perfectly happy to prescribe generic medication, but they like to be able to hand something to someone and then ask them to fill a prescription.

One aspect of our program is that we have actually put generic samples in the hands of physicians, so that they can choose a generic if they choose to, instead of the latest, greatest, most expensive medication.

Over the course of -- when we first started measuring this in early 2002, our generic prescription rate was 43 percent. When we remeasured the end of December 2003, it was up to 49 percent. So that was a significant increase. And at the present time, the nationwide average is around 44 percent. So we feel we are making an impact and ahead of the curve.

Q. Why does Premera provide these facilitation care programs?

A. I think it goes back to what I said earlier about providing high quality of care. Our belief is that high quality care in the long run is cost-effective care. If people are preventing their conditions from developing, if they are living healthy lifestyles, if they are doing the proper things that they need to do if they have a chronic condition, then the long-term outcome is a good one -- not only for them in terms of their health -- but also in terms of their cost containment.

Q. How have these programs impacted utilization?

A. They have impacted utilization in a variety of ways. The generic prescribing example that I just gave is one

example.

In terms of the case management programs -- again, as I said earlier, we don't do utilization management in the old-fashioned sense. Instead, we try to target that six percent of the population that's responsible for 60 percent of the healthcare costs. So, again, our programs for case management target that population. Our programs in disease management target that population.

If we have limited resources, then it makes sense to go in that direction, rather than the old mother-may-I approach.

Q. Have Premera's care facilitation programs been well received?

A. They have. The programs that I have described, in terms of the case management programs, we survey both members and physicians on an ongoing basis. We started doing those surveys -- and these are informal surveys, not detailed surveys -- that we do an on ongoing basis, about every quarter. Starting early 2002, we have consistently been in the 92 to 94 percent range of meeting or exceeding expectations.

Q. Dr. Chauhan, as a final question, can you tell us -- I mean, as a physician, what aspect of these efforts are you most proud of?

A. That's a tough question to answer because I am proud of many of them. Both our case management programs, our disease management programs, our poly-pharmacy programs, they all touch members' lives, and they touch them in significant ways. So that gives me personal gratification as a physician.

At the same time, when I talk to the physician community about our programs, they are -- I don't know how to say this -- they are pleased and enthusiastic about the approach that we have taken.

Brian said earlier -- Mr. Ancell said earlier that the American Medical Association has invited us to speak at a couple of symposia, both nationwide, as well as in the western region. Premera's being an example of how health plans and providers can work together.

When we hear statements that they make like that and invite us to participate in these, that gives us a good feeling that we are on the right track and doing the right thing.

MS. EMERSON: Thank you, Dr. Chauhan.

CROSS-EXAMINATION

BY MR. HAMJE:

Q. Doctor, my name is John Hamje. I a special assistant attorney general, appearing on behalf of the

OIC staff. Good afternoon.
A. Good afternoon.
Q. I have just a few questions for you. I am referring to your prefiled direct testimony, P-40. Page 11, you state, regarding the various programs you have been discussing, that, "Development and expansion will require ongoing investment by the company." Did I get that right?
A. Yes.
Q. Will remaining a non-profit organization impede Premera's ability to make the ongoing investment required for development and expansion of these programs that you have been talking about today?
A. Could you clarify what you mean by impede?
Q. Affect it adversely?
A. I don't think it would affect it adversely. I think it would take longer to develop additional programs. I think Mr. Ancell said earlier that in order to expand these programs we have to have the capital for the infrastructure necessary to -- in his example -- bring on additional nurses for case management. So that would be an example.
Q. So it would -- all that remaining a non-profit would be -- in terms of affecting these programs -- would be that it would delay their development and expansion; is

that correct?
A. I don't know that if it is all that would delay it. Again, I am not an expert in that area. I am a physician, and the work I do is related toward the clinical aspect of these programs. But I think it is safe to say it would take longer.
MR. HAMJE: That's all I have. Thank you, sir.
MS. HAMBURGER: I have no questions.
MS. EMERSON: No redirect. May the witness be excused?
COMMISSIONER KREIDLER: In a minute.
MS. EMERSON: I am sorry. My apologies.
COMMISSIONER KREIDLER: You are not alone.

EXAMINATION

BY COMMISSIONER KREIDLER:
Q. Dr. Chauhan, one of the examples here, where you are talking about disease management -- as I thought a little bit about this, I was wondering -- how do you deal with, in the case of diabetes, where infection is involved and a physician says, "I want to have them back every week," and yet perhaps your management standards for something in this category it should be once a month. How do you resolve that?

A. I am not sure I completely understand the question, let me try --
Q. Let me try to be a little more clear, if I can. If a physician wants to see a patient more frequently than what Premera has put forward as guidelines for that disease management -- presuming that there are, I am second guessing part of the disease management would involve guidelines for handling a particular type of diabetic-related problem, such as chronic infection. And that physician chooses to see that -- feels that that patient needs to be seen more frequently than perhaps the guidelines would indicate, how is that difference resolved over time?
A. Okay. If I gave the impression that we require physicians to follow guidelines for the management of a chronic condition, I apologize.

There are two types of disease management programs, in the broadest sense of the word. There are member-centric programs and there are physician-centric programs, and I think if I explain the difference between them that will help answer the question.

Physician-centric programs are the programs that follow the model that you just described, where there are specific guidelines that a vendor or a health plan may choose to use. And then they look at the physician

practice, and they say you are not following the guidelines. And they maybe say it in a nice way, but that program is targeted towards working directly with the physician.

Member-centric programs focus on supporting the doctor-patient relationship. The physician is in control. The physician is the one making the decision that his or her best judgment applies to that individual.

Our programs give the members additional information about their condition. So if we go back to the example of diabetes, a physician may or may not give the patient sufficient information for them to completely understand their condition. Our programs help give them that information and then also fill in the gaps, bridge the gaps between the doctor visits.

If, in the judgment of the physician, that patient should be seen on a weekly basis or a daily basis, that's up to the physician and we don't intervene in any way. That's between the physician and the patient.

Our goal is to give people information so that they are doing the things that they should -- that they -- they should be playing a more active role in.

So there are certain standards that everybody follows for diabetes. For example, everybody in the

healthcare profession knows you should get a Hemoglobin A1C test approximately every three months. You should get an eye exam once a year. You should get a test to make sure you are not developing kidney failure from diabetes, on a regular basis, once a year.

We are not saying you didn't do this once a year, we think you should, or, you are doing this more often than that and we think you shouldn't. We are just providing additional information, all from the same sources, about how you manage a condition like diabetes and putting it in the hands of the patient.

Q. I guess I am wondering what happens if the provider is essentially seeing a patient much more often than what would be considered part of what -- of the information that you were sharing with the patient and the patient making informed decisions as to what steps they should -- what actions they should be taking.

I am wondering though if it is in the provider's financial interest to see a patient more often, and Premera views that there is excessive use of -- utilization of healthcare services, how do you deal with that provider to try to reeducate them to perhaps -- so they don't bring the patient back quite as often, in fact the standards of care would dictate that the utilization of the services was uncalled for?

A. We don't -- I don't know how to say this. We work closely with the physician community, and what we do is -- by providing them the necessary information we are trusting their judgment that they are making the right decision to manage that member.

Now, I suppose there could be a situation that may have come in through a complaint from a member or a family member that -- is this the right thing to do, then in a situation like that, more often than not, one of the medical directors or myself would probably get on the phone and talk to that individual. But that's not our approach, in general. We don't look at practice patterns in that way and say to a physician, "We think you are doing things inappropriately," unless there is something egregious going on, in which case it has usually come in because of a complaint or some kind of abnormal billing behavior or something like that.

Q. What do you attribute then for perhaps control if there is a co-pay involved, things like this. I presume there is some incentives here for the patient, in addition, so that they understand that you can come in more often than might be suggested, but to do so then there is this co-pay.

Do you think the co-pay is part of the mechanism here to make sure that utilization is in part -- and I

am again talking about the extreme relationship as opposed to the standard.

A. I think the answer to that is yes, but it is a qualified yes, in the sense there is probably a lot more going on in addition -- that goes through the mind of the patient as they come into the doctor's office.

Part of them may say -- if they are being asked to come back more often than they think is right, I would hope that they would bring that issue up with their physician and talk about it.

Unfortunately, not everybody would have the wherewithal to do that, maybe they think it is inappropriate to question that. Maybe I am missing something here.

Q. I am thinking of a patient who might want to come in more often -- let's say it is asthma, and it is a child and the mother, every time that there is a deep sigh, is running off to see the physician.

A. Again, I think that our goal is more -- we don't impose any sanctions on the physician, we don't discourage the patient from going to see their doctor. But if we can put information -- I will give you an example.

Ear infections is something that -- for many, many years, everybody -- physicians and lay people alike --

thought you had to be seen immediately, thought you had to be treated with an antibiotic.

A few years ago we learned that 50 percent of ear infections are caused by viral infections. Now it is 75 percent of ear infections are caused by viral infections, so you don't need an antibiotic.

So an example there was we had a population of individuals who were going to the emergency room every time they had an ear infection. We sent them some information in the mail in the form of a coloring book that told a story about ear infections, that the patient could go through with their child, and it talked about the pain and how to alleviate the pain, and the kinds of things that one can do.

Again, we didn't stop them from going to the emergency room, we didn't tell them not to go to the doctor's office, we gave them some information they could use.

Again, in a situation like that, we -- the coloring book -- as the child is coloring and the parent is reading it to them -- they mention the nurse line as an option. Again, that sparks a thought and someone goes let me call the nurse line and see what I should do, do I need to go to the emergency room. Again, by taking a different approach to that we can achieve the same

ultimate outcome.

COMMISSIONER KREIDLER: I am particularly familiar with pink eye and very high percentage of them that are viral.

THE WITNESS: Yes.

COMMISSIONER KREIDLER: Anyway, thank you very much.

MS. EMERSON: Just one redirect question for clarification.

REDIRECT EXAMINATION

BY MS. EMERSON:

Q. Dr. Chauhan, in response to Commissioner Kreidler's question about approaches to care facilitation. You described two types or two different approaches, one would be physician-centric, the other would be member-centric. Does Premera follow one of these approaches or the other?

A. We follow the member-centric approach.

MS. EMERSON: Thank you, Doctor, no further questions.

MR. HAMJE: No questions.

MS. HAMBURGER: No questions.

JUDGE FINKLE: Thank you. Please step down.

ALAN SMIT, having been first duly sworn by the Judge, testified as follows:

DIRECT EXAMINATION

BY MS. EMERSON:

Q. Good afternoon, Mr. Smit. Can you please state your full name and spell your last name for the record.

A. Alan Smit, S-M-I-T.

Q. Who is your employer and what is your position with that employer?

A. I am employed by Premera Blue Cross. I am the company's chief information officer and a senior vice-president.

Q. What are your duties as chief information officer?

A. My responsibilities include the development and delivery of the uses of technology that we use in the organization to support our business strategy.

I also serve as the chair of the Blue Cross and Blue Shield Association Interplan Technology Advisory Committee, and I represent Premera as a founding member on the board of One HealthPort, a Puget Sound organization formed to create a single security portal through which providers and their staff can get at the on-line services at the local large health

organizations.
Q. Can you describe for us, please, your educational background?
A. Yes. I have a business -- Bachelor of Arts in business and accounting from Augustana College, and a Master of Business Administration from University of South Dakota.
Q. Can you please give us an overview of your professional background prior to the time that you assumed your current position at Premera?
A. Prior to joining Premera in 1997, I spent nine years with Trigon Blue Cross/Blue Shield in Virginia. I was corporate vice-president of corporate information systems there. And prior to that, I was a senior consulting manager with Accenture in Atlanta, Georgia.
Q. Now, your prefiled direct testimony, which was marked as hearing Exhibit P-68 has been filed and served in this proceeding. Do you adopt that testimony?
A. I do.
MS. EMERSON: Mr. Smit's prefiled direct testimony is marked as Exhibit P-68. With the adoption of that testimony, Premera would now move to admit that exhibit.
MS. DeLEON: No objection.
MS. HAMBURGER: No objection.

JUDGE FINKLE: Admitted.
BY MS. EMERSON:
Q. Mr. Smit, could you please look in your notebook at Exhibits P-69 and P-71 through 74. Are Exhibits P-69 and P-71 through 74 the documents that are referenced in your prefiled direct testimony?
A. Yes, they are.
MS. EMERSON: At this point Premera would now move to admit these exhibits.
MS. DeLEON: No objection.
MS. HAMBURGER: I just have a question. Is the press release referenced or the GAO report that's referenced in the prefiled testimony?
BY MS. EMERSON:
Q. Can you identify please, Mr. Smit, Exhibit P-74?
A. P-74 is Premera's press release that described the GAO report.
MS. HAMBURGER: I understand that's what P-74 is, but I am wondering if the more appropriate exhibit would be the actual GAO report. That's what -- the GAO report is what's referenced in the prefiled direct.
THE WITNESS: That information is available, I believe.
MS. EMERSON: We would be happy to supply it

if that's the request that counsel is making.

MS. HAMBURGER: I object to the use of the press release. It is not the best evidence, and it is not what's referenced in the prefiled direct.

JUDGE FINKLE: Is the report itself an exhibit?

MS. EMERSON: It is not. The press release contains -- well, if I could pose a question to the witness?

JUDGE FINKLE: Sure.

BY MS. EMERSON:

Q. Mr. Smit, are you familiar with the press release?

A. Yes, I am.

Q. Did you rely on the information from the GAO report in preparing that press release?

A. Yes, we did. We received a copy of the GAO report before we elected to create the press release.

MS. HAMBURGER: I still object. It is not the best evidence.

JUDGE FINKLE: This is one where we are in a -- I would sustain the objection in a trial, but we are in an administrative proceeding. I will admit the exhibit, but also permit the record to be supplemented by the report itself, if you would like. Do you have that? If not, I will ask Premera to make it available

to you.

MS. EMERSON: We will certainly look for that and bring it to the hearing on Monday.

JUDGE FINKLE: I mean, we do need representation by the witness about whether or not the Exhibit 74 is an accurate reflection of the contents of that report. Maybe we had it, but if we could get that clarified.

THE WITNESS: I believe it is.

JUDGE FINKLE: Admitted.

BY MS. EMERSON:

Q. Mr. Smit, your prefiled testimony addresses three key factors that are driving healthcare organizations to invest in technology at an accelerated rate. Can you briefly summarize those factors, please?

A. Yes. I believe that the factors driving us to spend an ever-increasing amount on information technology and that sort of architecture fall into three major categories. The first largest -- and probably not the most surprising -- is the market itself. What our customers are wanting, expecting and asking for from us in the form of service information and value.

And then what our competitors -- who hear those same expectations -- are doing in response, and as our competitors react, so must we.

The second category is a trend I see happening in the industry to integrate the multiple business organizations that make up the healthcare delivery system -- the small practitioners, the pharmacies, the large healthcare institutions, the payers -- and to integrate their technology environments between each other to better share information, to make the system more efficient.

And then finally, there is a regular set of requirements coming through the legislative and regulatory mandates that I think we will actually be seeing an increase in those environments in the upcoming years.

I think all of this is showing up in a study recently done by the Gartner Group, a technology industry watchdog, who is predicting that the compounding annual growth rate of technology has been in the healthcare industry, will be seven percent in the upcoming years, larger than virtually any other industry except the government itself.

Q. Why don't we talk about each of those three factors as drivers that you just identified. Let's start by addressing the competitive forces and customer expectations.

Can you explain more about competitive forces?

How do you see this as driving Premera to invest in the area of information technology?
A. Well, as I mentioned, our competitors see the same market demands that we do and are very aggressive about responding to those and trying to create their own competitive sanctions and advantage. It now therefore makes information technology a linchpin of how you compete.

We compete, as it has been mentioned here, with local regional entities, such as Regence, as well as national entities, such as United, Aetna and CIGNA.

Part of my role as the CIO is to understand our industry, its demands, Premera's business strategy, and bridge that technology strategy. So I have to keep up-to-date with what those competitors are doing.
Q. What is it about customer expectations that are pushing Premera's need to invest in IT?
A. Well, the marketplace wants certainly price, a very cost-effective, affordable health insurance, made up with the clinical costs, as well as the administrative costs.

One component of the cost that they care about is the administrative cost of the system. And our ability to control our administrative cost and to assist in controlling the administrative cost of the entire system

is very dependent -- not totally dependent -- on our ability to implement technology.

In addition to that, however, they want a lot of information. They want information available in a readily-usable format, customized to their needs, and when they want it.

And then finally, they want good service. They want the kind of responsiveness to their problems or their requests that they see in many other industries.

All of that just leads to a variety of requirements that I see showing up in the requests for proposal that we get from our customers. I see it in market research data that participated in the reports on, as well as in the discussions of market requirements that we conduct with our executive management team.

Q. Does the Premera sales and marketing group coordinate with you and your team on customer demands for information technology?

A. Very much so. We typically address a given market opportunity or a specific client opportunity with a cross-functional team in the organization, and frequently have IT staff in those teams -- and more and more frequently actually presenting directly to the customer -- because their expectations have gotten them down to some very specific requirements and requests

about our technology.
Q. Your prefiled testimony discusses Premera's investment in the systems that support the Dimensions initiative as an example of how the company uses technology to improve its product offering.
Can you please tell us how the company came to make the decision to invest in that technology?
A. Sure. It is -- I guess I would call it pretty much a textbook case of matching technology needs to the business plan. In '99 and 2000 the company was looking very hard at what its vision needed to be about delivering a new generation of products, services, and networks to the market, in response to the need for affordability and choice going forward into this decade.
We were able to map out those business requirements, but had to step back and look at whether our underlying systems and technology would be able to deliver on that, and the assessment was that it couldn't at that stage.
Over the years we had built and put in place multiple core systems to administer the membership and claims of our members, not reacting to the '80s and '90s and the various solutions delivered to market at that time.
Those systems were built -- at the time they were built -- with the best disciplines of the time for the

use of technology and the design of systems. But they didn't age any better than perhaps I do, and we are getting more rigid, inflexible, and it was getting harder and harder to change as the market keeps asking for more.

So we decided we needed to implement a new core system to unify in one place all the services from membership and claims, and to do it on the latest technology so it would be more flexible and continue to be able to change as we respond to the market going forward.

We have done that. We used a software vendor solution for the core system, which gave us a lot of precoated, powerful options as to the way to provide product to the market, and then we extended it where we felt appropriate for our own needs.

Q. How the Dimensions systems platform met the company objectives?

A. Very much so. It allows us -- it has allowed us to deliver -- as what you have heard -- the Dimensions program, where we have been able to leave behind the typical structures of product in the industry, where a single network choice was frequently associated with a single benefit choice, which came with a prepackage requirement for healthcare management. And we were able

to unbundle and offer those as individual choices, thereby, giving our customers more ability to make their own decision, and the trade-off of choice versus cost.

Q. What has the company done to improve technology for web-based services?

A. Well, clearly, part of the business vision in 2000, which was during the height of sort of the dot-com craze, was that you needed to E-enable your business and give your constituents 24-by-7 service.

Particularly, our members are becoming very accustomed to that kind of capability because of the investments that financial services companies and retail observations made in the '90s. That's sort of become the norm how you interact with those organizations.

Even though our interactions with our customers are much more complex than in those businesses, they were expecting that same type of web-type of capability.

So we invested heavily in that as part of the Dimensions project, and integrated -- from a cost-effective point of view -- only to the newest systems, and now deliver a robust set of capabilities and individual portals to the different stakeholders we participate with.

So providers, brokers, groups, members, each have their own solutions. In the case of a member, they can

come in and look up the providers in our network, in our provider directory, instead of relying on a paper directory that's out of date.

They can get on-line and look at their benefits -- including their year-to-date deductible status -- as well as the status of a particular claim that they have in flight, where they may have received a bill from a provider, they are not sure what their liability is, and they can see if we have adjudicated that claim yet.

Finally, as Dr. Roki described, that we have health information available, that they can look up particular health information, such as childhood diseases, or particular information about a chronic disease they may be experiencing.

Q. And we have heard in prior testimony that approximately 125 million dollars was invested by the company on the Dimensions initiative. Is that your understanding as well?

A. Yes, correct. That's the approximate amount that we invested in the program to build -- not only the new products and services -- but the underlying technology infrastructure. That represents -- I will call it the core technology infrastructure of the company.

Our claims and membership system is the backbone of our business, but it is not all the functions we

provide.

Going forward now, around that new core, we are going to have to continue to invest in technology to enhance our support of all the other business functions we have in the company, and then to start reaching even further outside of the company with electronic integration to all the stakeholders I described before.

Q. Could Premera compete for customers and business without providing these technology-based services?

A. There is really no choice in this day and age. Information technology to a financial services organization, such as ourselves, is the manufacturing plant of a manufacturing company. And they cannot create product without that plant, we cannot deliver product and service without information technology.

Our competitors are investing very aggressively in it. If we didn't do so also, we would not be able to complete.

Q. Let me follow up on that point about the competitors and their efforts. How vigorous are those efforts by competitors? Can you describe that for us, please?

A. From where I sit, it is very vigorous, because I have to figure out a way for Premera to compete with it.

CIGNA has nearly completed a multi-year, one-billion-dollar project to replace their core

technology to deliver their new products on that platform -- so, in concept, not dissimilar to our project.

Locally, Regence is in the middle of a multi-year project to implement a new complex sophisticated core processing solution also.

United Healthcare has been renowned for years in their aggressive implementation in use of technology, as evidenced by the fact that we estimate -- and I have seen them discuss publicly -- that their annual capital investment in technology is 10 times what Premera can do.

Now, because of their size, that's not surprising. But the difficulty is that we need to be able to do -- on a per member basis or as a percent of revenue -- we have to be able to compete in how much we invest in technology, and we need to grow our membership base so that we have the basis for investing more in technology.

So all of these entities are working very aggressively. United's most recent public announcement is to deliver smart cards to their 10 million members or more within the last year and half, so that when that member walks into a member office they can swipe it through a machine and immediately have access to United's systems for eligibility and membership

information on that member.
Q. Can you -- could Premera's 125-million-dollar investment in Dimensions be characterized as a one-time investment that would not require additional financial resources?
A. No. Not at all. As I mentioned, we delivered a new core membership and claims system as part of this effort, and that's either the backbone or the heartbeat of the company, depending which way you want to characterize it. But automation, nowadays, goes way beyond that to nearly every business function in the organization.

I think it has been mentioned in previous testimony that our care facilitation programs require systems, and we would like to improve the systems that support the nurses in that context.

We have investments we want to make in extending our ability to reduce paper and bring in more things electronically from providers. So there is continued investments we want to make at some point, whether it is a smart card or some type of ability, to give cards to the member that facilitates the providers' ability, as I described with United, is in our plans.
Q. The second driver that you identified as pushing the need to invest in technology, was integration and

connectivity. Can you tell us how that integration will work?

A. Sure. I guess I compare that -- if you have heard the term -- in the manufacturing industry of supply chain integration. Manufacturing and retail organizations over the last years have created technology integration that brings closer together the parties that participate in the system or the value chain.

In the case of WalMart, their suppliers can see through their own computers what sold at WalMart today and predict what they have to now ship to replenish that supply, rather than waiting for WalMart to place an order.

The healthcare industry, as a set of individual operating entities -- from small provider practices, to the institutions and the financial entities -- is very disparate and has very heterogeneous environment, in terms of their technology -- some more sophisticated than others, many not very sophisticated yet.

While most of those entities have been investing in the last few years to improve their own internal uses of technology, the next logical step is that we create that supply of chain integration. We use technology to better integrate between the payer and provider, as well

as, the provider and provider.

It is really seen as the next best way of individual efforts to improve quality and improve cost effectiveness in the system.

Q. Can you give us a couple examples to illustrate how integration is or can work?

A. Sure. First, perhaps, an example on administration. We talked about the smart card, but it is very realistic that a member could walk into a provider's office in the future, and in a variety of ways -- that are all better today -- better than pulling out a copy of their member ID card -- that the provider can find out the latest information about that member -- verifying their health eligibility, health insurance eligibility, their benefit plan, the status of their year-to-date deductibles. Whether it is the member being issued a smart card that's swiped through a device in the provider's office, whether it is the provider getting on a browser screen, on a website, and making that inquiry directly on the payer's system, or whether it is the provider's practice management system -- when it scheduled that member -- that system -- automatically and without request -- fired off the request for that benefit information straight to the payer, the answer came back electronically, and that's there in the practice

management system when the member shows up.

We will not in the industry mandate in a single way, and we will probably have to build to all of those solutions, but all of them will enhance administrative efficiency.

The next layer on top of it is the provider doesn't want a different solution on their desktop for every payer. So they don't want the swipe card machine and the browser machine and the practice management system to all have to be operating, one for each payer that they deal with.

So we will be looking at sort of a network solution in the industry, where the question -- no matter how it is served up by the provider -- gets to any payer they deal with in the same way, and back again to get an all-payer solution.

The other example is in the clinical arena. This becomes much more provider-to-provider connectivity, but there is a role here for the payers also. And that is to make sure that an individual's health information is available, wherever it is needed, no matter whatever care setting they end up in. And that is sometimes referred to as a virtual patient medical record. Not that we bring together one large data store where all of your information personally, but we know where it is, or

we can access at the point it is needed.

The thought there is to drive a significant amount of costs out of the system and improve quality. The cost reductions come through analysis of reductions in redundant or unnecessary care -- because a particular provider does not know you have a test or does not know what the result was, but they would in that environment. Quality, because they may learn -- as we talked about earlier in the poly-pharmacy program, without having to bring a brown bag in -- which didn't show up on my examples of high technology, but it worked for that program -- without bringing a brown bag in, the provider can actually find out about all of your active prescriptions when you come to visit them, and thereby help with the pharmacy program.

There are -- I will call it -- early adopt or pilot programs that are going on all over the country as communities, and almost all at the community level make efforts to try this out, prove that it works.

We have a couple happening in Washington right now. The most notable one, getting the most exposure nationally, is the Santa Barbara County Care Data Exchange in California. They were funded with, I believe, 10 million dollars of money from the California Healthcare Foundation that we heard about, that was

formed in the Blue Cross plan converted there.

The data that has come from that particular study seems to be based on testimony in Washington. The primary source of the number that's now getting talked about in Washington, DC, is this type of an infrastructure implemented nationally, could save 87 billion dollars a year in healthcare at cost.

Q. Can you please provide an example or two of the investments that Premera has or will need to make to support integration and connectivity?

A. Sure. To date, we have attempted to get involved in the community and lead some efforts. The Dimensions program in the last couple of years has kept us quite focused on our internal efforts but we expect to be looking outwardly at much more of it. Obviously, we built our premera.com, which gave the providers the ability to a browser screen, to look directly to us and interoperate with us.

However, as I mentioned, providers would prefer all payer solutions and we are aware of that. So we made an additional investment and worked with a company called Siemens PointShare, who was delivering to the providers in this market and all payer solutions.

So, for instance, a provider could look up eligibility information through the same screen, the

same look and feel, to any payer who would agree to cooperate and coordinate with Siemens, which we went ahead and invested to do that so it would be easier for the providers.

We also were a founding member and invested in the One HealthPort, as I mentioned. We were worried that, as everyone rushed to provide a dot-com capability, every provider would have that many more yellow sticky notes on their monitor about their security and their password for every one of those, which doesn't enhance security at all and increases a certain amount of complexity. So we invested in building and delivering a solution, and then invested again to integrate it to our existing provider portal, so that a provider or their office staff has one security credential, and once they deliver it up to a browser they can then look at the web capabilities of any entity that wants to participate with a security portal -- as do we, Regence, Group Health, that type of thing.

Q. Thank you. The third driver or factor that you identified was the legislative and regulatory requirements. Can you explain how these factors are also driving further investments in information technology?

A. Sure. As I discussed, the industry from a business

unit point of view -- as some people would say -- is a cottage industry. It is very broken up into a variety of different quasi-independent entities.

It is also, as everyone knows, such a complicated business. The number of data elements in a claim record is exponential over the number of data elements in an ATM transaction.

So this industry has not gotten as far along in the integration I just described, in setting the development of the standards that it takes to achieve that integration as other industries, and that has been noticed in Washington, DC.

I have said HIPAA for so many years now I have to pause to recite it, but the Health Insurance Portability and Accountability Act of 1996 was obviously the most recent largest effort to start addressing that. One of its components was setting up standards for key transactions in our business and mandating those standards to be followed if anything was going to be done electronically.

It also included security and privacy requirements. By far the largest technology implementation was the transactions and code it sets that were standardized.

The industry has had a couple of years to become compliant with that. The estimate by Health and Human

Services in about 2000 is that it would cost the industry about 18 billion dollars, I think it was, to comply with those.

A known study, later in 2001, estimated it was probably going to approach 40 billion, and I am sure we will never know where in between there it exactly came out.

Premera, by the end of this year, I believe we will have invested 34 million in becoming compliant with all the HIPAA efforts that we addressed to date, and we are still working on things like security, which is due next year.

So a very, very large effort requires significant changes in our systems, and we are today actively working, continuing to work, with all the providers in the market that submit electronically to us. Because not only do each of us have to get our systems to now be compliant with these new standards, we have to talk to each other again. We already pass data back and forth, but now we are doing it in a new way, and we have to debug that. So we are continuing to invest in that.

Q. What are the government-sponsored initiatives that are on your horizon right now?

A. One of the large ones we are monitoring, HIPAA allows for additional standards to be delivered without

additional legislation, and those standards that deliver them will be updated every year. And we will, whether it meets a local business need or not, be required to make the changes that stay current with those standards.

One of the largest new standards we look at is the changeover from the ICD-9 diagnosis procedure coding scheme to the ICD-10 scheme -- and there is a lot of interest nationally in that, but from certain entities.

However, again, a study has said that could cost as much as 14 billion dollars for the industry to comply with those standards. So it is being looked at very carefully. I believe, at some point, it will probably come.

In addition to that, as I mentioned with Washington's interest in this issue with the use of technology in our industry, there are a whole variety of proposed actions and legislations and acts that would create, in one form or another, something of a national health information infrastructure. And one of those nations actually uses that term, but I would bundle all of them under that label, and there are several being proposed.

It is essential to either encourage -- through forcing of standards or through support of funding -- or to potentially even legislate the need for that

integration I already discussed. And that is being discussed, along with this 87 billion dollar a year savings number that has been put forward, which gets a lot of people's interests.

So we are watching that very carefully. It will have a huge impact on the provider community, but what's being said right now is that the benefits in many cases -- such as, electronic medical records for the physician practice doesn't benefit the physician. There isn't an economic benefit, in fact, it reduces utilization if used inappropriately. So I know there is an interest in how will payers be able to help with this investment. The benefit they believe would be to us if it is underwritten business or ultimately to the customers.

So there is a lot of movement out there for that right now. Ironically, as I mentioned, it was the Santa Barbara effort that was used so far as the extrapolated number to the national number.

Even just in the last two weeks, President Bush in a statement said he wanted to form an office in HHS to address it -- and the title escapes me, but it is a national information infrastructure office. And amazingly, already they have appointed the head of that office, Dr. David Brailer, I believe it is, who was

actually the architect of the Santa Barbara effort.

There is going to be some action around this. Ex-Congressman Gingrich has been proposing that by 2005, perhaps, they should mandate that an electronic medical record be in use by anyone to see a Medicare patient. So just a huge amount of momentum would appear to be building up around this.

Q. We have now talked about the competitive customer, the integration, and the regulatory factors that are driving an investment in technology. Can you tell us, how have these factors affected Premera's actual and projected spending on technology?

A. We have nearly doubled how much we spend on information technology in the last four years, and I do not see any basis for saying that is going to go down. That was not a bubble.

We are proud of what we have accomplished with it. There is a lot more we want to do. We mentioned earlier the exhibit where the Government Accounting Office visiting and going nationally talking to organizations in the financing side and healthcare delivery side, I believe, in support of some of these Washington initiatives, to try to determine how much technology is being used in the industry. It was fairly complimentary of Premera and our use of the information we gathered.

Because we have talked a lot today about our claims and membership processing. In the course of that, we literally collect millions and millions of records about our members, as well as their healthcare. It is a shallow data set clinically, but it is a very broad one. And it does have value in our ability to do things like analyze the source of trends, analyze the impact of practice patterns, help identify people who would be best served by disease management programs.

And we have been cited for the fact that even though we see a lot we have left to do there, we are already demonstrating value.

Q. What does all this mean for Premera going forward?

A. Without a doubt, I believe strongly in our mission, our peace of mind. I have been in the industry long enough to realize how challenging it is to do this in a situation with a country in healthcare, and it does take a lot of capital to deliver on the technology that we have to have to deliver on that vision.

MS. EMERSON: Thank you, Mr. Smit.

CROSS-EXAMINATION

BY MS. DeLEON:

Q. Good afternoon, my name is Melanie DeLeon.

A. Good afternoon.

Q. I am with the AG's office. I just have a few quick questions.

Isn't IT improvement and technology a challenge for every business?

A. Yes, it is a challenge and a market demand.

Q. I understand that sophisticated IT is not an option in the healthcare industry, but it is a competitive necessity; is that correct?

A. That's correct.

Q. That's true for all healthcare insurers, not just Premera?

A. That's correct, in my opinion.

Q. And this would be true whether you converted or not; is that correct?

A. Yes.

Q. Now, when you update or modify or improve your IT systems and infrastructure, isn't there also an associated cost savings?

A. We certainly look for the projects that can deliver direct cost savings. They tend to get a little higher priority when we bring them forward.

Many of those -- however, the cost savings are out there a number of years -- but the investment is now. So we tend to be faced with current investments and future cost savings.

But a significant -- and I would guess, though I have not analyzed it -- the majority of them add to service opportunities to our members -- which doesn't actually change the cost structure -- and add value and form of the information we can deliver to members that's important to them in deciding and controlling their healthcare.

Q. For instance, if you have web-based information, that a consumer can go on at midnight and look up, wouldn't that reduce the requirement for you to have a call center?

A. We are waiting to see nationally -- back for a second. The experience of the financial services institutions that are a number of years ahead of healthcare in this would say no to some degree. In other words, an inquiry in our website at night did not eliminate a phone call the next day. It is a net increase in transactions. I think that's been shown over and over again.

We do hope to see eventually a reduction in the questions on the telephones. But, I would tend to say that -- besides in the investment we have made in the web services -- will not get a greater than that reduction in the other service channels. We would probably do well if we could equal, but the net--it

added better service for our members, which is what they are asking for.

Q. In the P-74, the GAO report, you highlight some projects that Premera has done; is that correct? And one of them is Eliza?

A. Correct.

Q. Can you describe that briefly?

A. Certainly, I can attempt to. That would be in Dr. Roki's area, but we contracted with a vendor who delivered the technology of speech recognition, so that it was much more efficient to execute a program of surveying members than to have to do the usual mailings and repeat mailings.

Then we built the technology inside of Premera to extract the data we need and to provide the integration to that member so that the Eliza tool actually had the information needed to conduct the surveys, the computer-generated voice recognition surveys.

Q. It says here that the reminder calls made by using the Eliza technology were not only 10 to 30 percent less costly than calls made by live operators, but they contributed to increases in diabetic eye care.

So, in that case, you did reduce the calls for life operators; is that correct?

A. Yes. That is an example where we get a double

benefit, with administrative a little less expense, but also much more effective as a program, because of the speed at which we can get done with the contacting of all the program membership.

Q. Further down the page you talk about the OCR Imaging and Scanning Technology, and it reduced administrative costs by about a million dollars in 2003?

A. That's correct.

Q. Do you get to roll those savings back into IT services?

A. No. We will usually take a balance between taking those to the bottom line -- part of what we discussed earlier today, we believe we can achieve some of our goals for operating margin increase by reducing admin costs. That is one of the types of projects we give a high priority, because it has a fairly direct correlation.

Q. When you are doing your -- do you have to prioritize your IT projects?

A. Absolutely.

Q. And do you do a cost/benefit analysis on those?

A. We do a cost/benefit analysis with the dollar sign, tangible benefits on those programs you really expect to get a dollar savings.

The type of a project where we can provide

information that gives a better understanding to our groups about what's causing health care cost trends to go, has no dollar benefit, per se, it is very direct.

There we have to rely more on what the market is telling us about the information is what they want, how badly they want it, whether our competitors can deliver that information. That can generate its priority.

Q. If you have a project that would actually eliminate the need for a human being doing the actual work?

A. Yes.

Q. Do you use the savings from that to amortize the project at all?

A. Well, the savings usually is part of the justification. If we have eliminated positions, there will tend to be a savings in that department where that person was employed. We generally amortize the cost of the technology in my department. I don't usually get to see the savings.

Q. You said you have nearly doubled the budget in the last four years?

A. That's correct.

Q. That was prior to -- that's going to be the same whether you convert or not; is that correct?

A. Well, that's history, that's done. And whether we convert or not, I believe we are going to have a market

demand to continue to spend at that level.
Q. Has Premera been unable to implement any necessary IT projects due to the lack of funding?
A. Yes. Every year we go through a prioritization exercise -- and you said necessary projects, there is always judgment about which is most necessary. But every single year we have to take a look at our capital position, our resources, and clearly not all projects make it through the cut.
Q. All right. Do you believe that if the company became publicly-traded that you would have unlimited funds for IT initiatives?
A. Absolutely not.
Q. You would still have to prioritize projects?
A. We will still be making prioritization calls.
Q. You testified about how the HIPAA has required IT spending. Isn't that all about done -- all but done with, I think, April of 2005 being the last deadline?
A. No, it is not. April is the last deadline -- actually, that's not true. April is the deadline for the security rules, which are finalized. They have now also finalized the rules for the national provider identifier, its deadline is out a couple of years.
We are in the midst of sizing up what that could mean to us in terms of the investment in changing our

system. They are now taking the claims attachment standard through the process they use to finalize a standard. We fully expect those standards to be out within a year, and that will require that we implement electronic transaction types that don't exist today.

As I say, ICD-10 could be mandated within the HIPAA process without legislation, so I do not expect it to be done by a long shot.

Q. But the ICD-10, it is still being debated, is it not?

A. It has been recommended by the organizations who make the recommendations on standard setting, but it is still being debated as to whether -- when to do it and how rapidly to do it.

MS. DeLEON: I have no further questions.

MS. HAMBURGER: I have no questions.

MS. EMERSON: I think just one.

REDIRECT EXAMINATION

BY MS. EMERSON:

Q. Mr. Smit, are you aware of any capital constraints within the company limiting the company's ability to invest in the Eliza technology that was referenced in connection with the GAO -- referenced in the GAO report?

A. I am not aware of any limitations as related to that

particular initiative.
Q. Are you aware of capital constraints limiting other IT initiatives within the company?
A. Yes. As I mentioned, we do prioritization every year with the available capital, and there are initiatives that we can't get done. We tend to prioritize -- obviously, legislative and regulatory mandates are going to get a high priority.

Next would tend to come that which was being directly requested by our customers, and we need to respond to our competitors well or already have.

Next comes the longer term positioning investments that we want to make in the case of the integration industry. As I said, that's a positioning investment in the whole industry that we, long term, can add to cost savings. Those will tend to get a lower priority.

We have not been able to make some investments we have wanted to integrate with providers for real-time claims adjudication that we think would be very valuable for the member and the provider to get a better settle on the member liability before the member left the practice.

We need to develop that, we need to experiment with providers to see how it best works in their practice settings, and we have not been able to get to that.

MS. EMERSON: Thank you. That's all I have.

RECROSS EXAMINATION

BY MS. DeLEON:

Q. Do you believe capital constraints will suddenly disappear if you convert?

A. No. I think that they will -- as we have discussed, they become less of a long-term challenge. They will clearly not disappear overnight.

This conversion, as proposed, is a long-term financial management/risk management strategy. If it better enables us to grow our membership while keeping adequate reserves, I have a better ability to invest more in technology and spread it across that membership.

If it provides us better short-term financial alternatives, how to finance a particular technology effort that we must do, it leaves us a better ability to manage the company's finances that way. But, no, it does not totally limit the challenge of prioritization.

MS. DeLEON: Thank you. No further questions.

MS. EMERSON: Nothing further.

JUDGE FINKLE: Thank you. Please step down. I think we are done for the day, but let's take a quick check of where we are in the overall proceeding. What

is Premera expecting for Monday?

MR. MITCHELL: Judge Finkle, if I am counting correctly we are through 14 of our 19 witnesses at this point, and that means that we should be able to get through all but one probably come Monday. So I think we are making progress, and I know all of us are thankful for it, and it would appear that's -- it is conceivable we could finish on Monday. I think that unlikely, but we certainly should be done by noon on Tuesday I would think.

JUDGE FINKLE: Any observations before we adjourn on the scheduling, any issues we ought to be aware of on procedure? Good. Well, we will see you Monday at 9:00.

(Proceedings concluded at 5:00 p.m.)

C E R T I F I C A T E

STATE OF WASHINGTON)
) ss.
County of Pierce)

I, the undersigned Notary Public in and for the State of Washington, do hereby certify;

That the foregoing Verbatim Report of Proceedings was taken stenographically before me and transcribed under my direction; that the transcript is a full, true and complete transcript of the proceedings, including all questions, objections, motions and exceptions;

That I am not a relative, employee, attorney or counsel of any party to this action or relative or employee of any such attorney or counsel, and that I am not financially interested in the said action or the outcome thereof;

That I am herewith securely sealing this transcript and delivering the same to the Clerk of the above-entitled Court.

IN WITNESS HEREOF, I have hereunto set my hand and affixed my official seal this 9th day of May, 2004.

_____
Notary Public in and for the State of Washington, residing at Tacoma.